

MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET

医学病史和身体检查表

For use with DS 2053 与 DS-2053 表一同使用

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| Name(Last, First, MI) 姓名(姓名) | | Exam Date(mm-dd-yyyy) 检查日期(月-日-年) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Birth Date(mm-dd-yyyy) 出生日期(月-日-年) | Passport Number 护照号码 | Alien(Case)Number 档案号码 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Past Medical History (indicate conditions requiring medication or other treatment after resettlement and give details in Remarks) 过去病史 (若有移民后需要医药或其他治疗的病症存在应标明并在备注栏内给出详细资料) Note: The following information has been self-reported, has not been verified by a physician, and should not be deemed medically definitive. 注:以下资料由申请人自述,为非医生认证的事实,不应做为医学结论。 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="0"><tr><td>No 否</td><td>Yes 是</td><td>General 一般情况</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Illness or injury requiring hospitalization (including psychiatric) 需要住院的疾病或外伤 (含精神疾病)</td></tr><tr><td colspan="3">Cardiology 心脏疾病</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Angina pectoris 心绞痛</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hypertension(High blood pressure) 高血压</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cardiac arrhythmia 心律不齐</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Congenital heart disease 先天性心脏病</td></tr><tr><td colspan="3">Pulmonology 肺部疾病</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>History of tobacco use 吸烟史 Current use <input type="checkbox"/>Yes <input type="checkbox"/>No 现仍吸烟 是 否</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma 哮喘</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chronic obstructive pulmonary disease (emphysema) 慢性阻塞性肺部疾病(肺气肿)</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>History of tuberculosis (TB) disease 结核病史 Treated <input type="checkbox"/>Yes <input type="checkbox"/>No 治疗过 是 否 Current TB symptoms <input type="checkbox"/>Yes <input type="checkbox"/>No 目前有结核症状 是 否</td></tr><tr><td colspan="3">Neurology and Psychiatry 神经和精神疾病</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>History of stroke, with current impairment 中风史,现有后遗症</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Seizure disorder 癫痫</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Major impairment in learning, intelligence, self care, memory, or communication 主要缺陷在学习,智力,自理能力,记忆,社交方面</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Major mental disorder(including major depression, bipolar disorder, schizophrenia, mental retardation) 主要精神障碍(抑郁症,躁狂与抑郁交替,精神分裂,智力缺陷)</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Use of drugs other than those required for medical reasons 非医嘱自行使用药物</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Addiction or abuse of specific * substance (drug) 滥用特殊物品 * (药物) * amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics * 安非它明,大麻,可卡因,致幻剂,吸入剂,鸦片类,循环苯吡啶,镇静-催眠药和抗焦虑药</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Other substance-related disorders(including alcohol addiction or abuse) 其他物品所致异常(包括:酗酒或酒精依赖)</td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ever taken action to end your life 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| Cardiology 心脏疾病 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina pectoris 心绞痛 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac arrhythmia 心律不齐 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital heart disease 先天性心脏病 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pulmonology 肺部疾病 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> | <input type="checkbox"/> | Asthma 哮喘 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> | <input type="checkbox"/> | Seizure disorder 癫痫 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Endocrinology and Hematology 内分泌疾病和血液系统疾病 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes mellitus 糖尿病 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disease 甲状腺疾病 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | History of malaria 疟疾病史 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other 其他 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Malignancy, specify 恶性病,详细说明 _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic renal disease 慢性肾脏疾病 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic hepatitis or other chronic liver disease 慢性肝炎或其他慢性肝病 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hansen's Disease 麻风病 <input type="checkbox"/> Tuberculoid <input type="checkbox"/> Borderline <input type="checkbox"/> Lepromatous 结核样型 中间界线类 瘤型 OR <input type="checkbox"/> Paucibacillary <input type="checkbox"/> Multibacillary 或 排菌量少 多种杆菌感染 Treated <input type="checkbox"/> Yes <input type="checkbox"/> No 曾治疗 是 否 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Visible disabilities(including loss of arms or legs), 可见残障(包括上肢或下肢缺失) Specify 详细说明 _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Other requiring treatment, specify 其他需要治疗的状况,详细说明 _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

2. Physical Examination (indicate findings and give details in Remarks)

身体检查 (注明体检所见并于备注栏内写出详情)

☐ No ☐ Yes Applicant appears to be providing unreliable or false information, specify
 否 是 申请人的临床表现与其所提供的资料不吻合或其所提供的资料有误, 详细说明

Height 身高 _____ cm Weight 体重 _____ kg Visual Acuity at 20 feet: Uncorrected L 20/ _____ R 20/ _____
 20 英尺处视力: 裸眼视 左 20/ _____ 右 20/ _____
 BP 血压 _____ / _____ (mmHg) Heart rate 心率 _____ /min Respiratory rate 呼吸率 _____ /min Corrected L 20/ _____ R 20/ _____
 毫米汞柱 矫正视 左 20/ _____ 右 20/ _____

* N, normal; A, abnormal; ND, not done

正常 不正常; 未做

| | | | | | | | |
|--------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|---|
| N* | A* | ND* | | N* | A* | ND* | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | General appearance and nutritional status 外观特征及营养状况 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inguinal region (including adenopathy) 腹股沟区(含腺体病变情况) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing and ears 听力及双耳 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Extremities (including pulses, edema) 肢体(含脉搏和水肿情况) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eyes 双眼 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal system (including gait) 肌肉骨骼系统(含步态) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nose, mouth, and throat (include dental) 鼻、口腔和咽喉(包括牙齿) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections) 皮肤(含色素沉着不足, 感觉缺失, 自伤或自行注射痕迹) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart (S1, S2, murmur, rub) 心脏(第1心音, 第2心音, 杂音, 摩擦音) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lymph nodes 淋巴结 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Breast 乳腺 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous system (including nerve enlargement) 神经系统(含神经束肿大表现) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lungs 肺 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Mental status (including mood, intelligence, perception, thought processes, and behavior during examination) 精神状况(含检查中的情绪, 智力, 感知力, 思维逻辑和行 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Abdomen (including liver, spleen) 腹部(包括肝、脾) | | | | 为) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Genitalia (including circumcision, infection(s)) 生殖器(包括包皮或阴茎环切术, 传染病) | | | | |

3. Additional Testing Needed Prior to Approving Medical Clearance

出国前需要加做检查以便确诊

No Yes

否 是

☐ ☐ Physical examination or laboratory results contradict medical history
 体检或实验室检测结果与病史矛盾

☐ ☐ Referral prior to departure if yes, provide results
 如果在出国前接受了会诊, 结论是: _____

☐ ☐ Referral prior to departure if yes, provide results
 如果在出国前接受了会诊, 结论是: _____

4. Follow-up Needed After Arrival

到美国后需要随访

☐ No ☐ Yes, within 1 week ☐ Yes, within 1 month ☐ Yes, within 6 months
 否 是, 1周内 是, 1个月内 是, 6个月内

☐ For continuing medication, list type, dose, and frequency
 需继续药物治疗, 列出药物的类别、剂量和服用次数 _____

☐ For continuing other treatment, specify _____
 需其他治疗, 详细说明 _____

5. Remarks (describe any abnormal history, abnormal findings, and resulting interventions)

备注 (描述过去病史, 体检中异常发现和结论)

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES

文字报告缩减法和个人隐私法之相关通告

Public reporting burden for this collection of information is estimated to average .35 minutes per response, including time required for searching existing data sources, gathering the necessary data, providing the information required, and reviewing the final collection. Persons are not required to provide this information in the absence of a valid OMB approval number. Send comments on the accuracy of this estimate of the burden and recommendations for reducing it to: Department of State (A/RPS/DIR) Washington, DC 20520 – 1849.

针对表中的要求对资料进行搜集并根据所得资料完成此表,估计每份平均需要 35 分钟。若持表人所提交的表上无美国预算和管理局给予的号码,这类人无需向您提供表中的相关信息。若您对于完成表格所需时间的估计和表格内容的精简有更好的建议,可告知:华盛顿特区的国务院所属机构(A/RPS/DIR),邮编:20520-1849

We ask for information on this form, in the case of applicants for immigrant visas, to determine medical eligibility under INA Sections 212(a) and 221(d), and, in the case of refugees, as required under INA Section 412(b)(4) and (5). If an immigrant visa is issued or refugee status granted, you will convey this form to the INS for disclosure to the Center for Disease Control and the US Public Health Service. Failure to provide this information may delay or prevent the processing of your case. If an immigrant visa is not issued or refugee status is not granted, this form will be treated as confidential under INA Section 222(f).

我们要求移民签证申请人或难民提供表中所罗列的内容,以便于我们确定申请人是否符合移民法第 212(a)221(d)或 412(b)(4)和(5)条中的医学要求。如果移民签证或难民身份获得批准,这份表格将提交到移民局从而将你的情况向疾病控制中心各卫生部通报,若不按照要求提供个人资料,你的申请程序将被延迟。若移民签证或难民身份未获批准,你的表格将依照移民法第 222(f)条的要求作为密件处理。

DS-3026

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