



U.S. Department of State  
**MEDICAL HISTORY AND PHYSICAL EXAMINATION WORKSHEET**

For use with DS-2053

OMB No. 1405-0113  
EXPIRATION DATE: 01/31/2004  
ESTIMATED BURDEN: 35 minutes  
(See Page 2 - Back of Form)

Name (Last, First, MI)	Exam Date (mm-dd-yyyy)
------------------------	------------------------

Birth Date (mm-dd-yyyy)	Passport Number	Alien (Case) Number
-------------------------	-----------------	---------------------

**1. Past Medical History** (indicate conditions requiring medication or other treatment after resettlement and give details in Remarks)  
NOTE: The following information has been self-reported, has not been verified by a physician, and should not be deemed medically definitive.

<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">No</td> <td style="width:10%; text-align: center;">Yes</td> <td style="padding: 5px;"><b>General</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Illness or injury requiring hospitalization (including psychiatric)</td> </tr> <tr> <td colspan="3"><b>Cardiology</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Angina pectoris</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hypertension (high blood pressure)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cardiac arrhythmia</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Congenital heart disease</td> </tr> <tr> <td colspan="3"><b>Pulmonology</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of tobacco use</td> </tr> <tr> <td></td> <td></td> <td>Current use <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Asthma</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic obstructive pulmonary disease (emphysema)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of tuberculosis (TB) disease</td> </tr> <tr> <td></td> <td></td> <td>Treated <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td></td> <td></td> <td>Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td colspan="3"><b>Neurology and Psychiatry</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of stroke, with current impairment</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Seizure disorder</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Major impairment in learning, intelligence, self care, memory, or communication</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)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Use of drugs other than those required for medical reasons</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Addiction or abuse of specific* substance (drug)</td> </tr> <tr> <td></td> <td></td> <td>*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other substance-related disorders (including alcohol addiction or abuse)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Ever taken action to end your life</td> </tr> </table>	No	Yes	<b>General</b>	<input type="checkbox"/>	<input type="checkbox"/>	Illness or injury requiring hospitalization (including psychiatric)	<b>Cardiology</b>			<input type="checkbox"/>	<input type="checkbox"/>	Angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac arrhythmia	<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease	<b>Pulmonology</b>			<input type="checkbox"/>	<input type="checkbox"/>	History of tobacco use			Current use <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease (emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	History of tuberculosis (TB) disease			Treated <input type="checkbox"/> Yes <input type="checkbox"/> No			Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Neurology and Psychiatry</b>			<input type="checkbox"/>	<input type="checkbox"/>	History of stroke, with current impairment	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	Major impairment in learning, intelligence, self care, memory, or communication	<input type="checkbox"/>	<input type="checkbox"/>	Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)	<input type="checkbox"/>	<input type="checkbox"/>	Use of drugs other than those required for medical reasons	<input type="checkbox"/>	<input type="checkbox"/>	Addiction or abuse of specific* substance (drug)			*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics	<input type="checkbox"/>	<input type="checkbox"/>	Other substance-related disorders (including alcohol addiction or abuse)	<input type="checkbox"/>	<input type="checkbox"/>	Ever taken action to end your life	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:10%; text-align: center;">No</td> <td style="width:10%; text-align: center;">Yes</td> <td style="padding: 5px;">Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs</td> </tr> <tr> <td colspan="3"><b>Obstetrics and Sexually Transmitted Diseases</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Pregnancy Fundal height _____ cm</td> </tr> <tr> <td></td> <td></td> <td>Last menstrual period Date (mm-dd-yyyy) _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Sexually transmitted diseases, specify _____</td> </tr> <tr> <td colspan="3"><b>Endocrinology and Hematology</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes mellitus</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Thyroid disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>History of malaria</td> </tr> <tr> <td colspan="3"><b>Other</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Malignancy, specify _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic renal disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Chronic hepatitis or other chronic liver disease</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hansen's Disease</td> </tr> <tr> <td></td> <td></td> <td><input type="checkbox"/> Tuberculoid <input type="checkbox"/> Borderline <input type="checkbox"/> Lepromatous</td> </tr> <tr> <td></td> <td></td> <td>OR <input type="checkbox"/> Paucibacillary <input type="checkbox"/> Multibacillary</td> </tr> <tr> <td></td> <td></td> <td>Treated <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Visible disabilities (including loss of arms or legs), specify _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other requiring treatment, specify _____</td> </tr> </table>	No	Yes	Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs	<b>Obstetrics and Sexually Transmitted Diseases</b>			<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy Fundal height _____ cm			Last menstrual period Date (mm-dd-yyyy) _____	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases, specify _____	<b>Endocrinology and Hematology</b>			<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	History of malaria	<b>Other</b>			<input type="checkbox"/>	<input type="checkbox"/>	Malignancy, specify _____	<input type="checkbox"/>	<input type="checkbox"/>	Chronic renal disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic hepatitis or other chronic liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Hansen's Disease			<input type="checkbox"/> Tuberculoid <input type="checkbox"/> Borderline <input type="checkbox"/> Lepromatous			OR <input type="checkbox"/> Paucibacillary <input type="checkbox"/> Multibacillary			Treated <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Visible disabilities (including loss of arms or legs), specify _____	<input type="checkbox"/>	<input type="checkbox"/>	Other requiring treatment, specify _____
No	Yes	<b>General</b>																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Illness or injury requiring hospitalization (including psychiatric)																																																																																																																																			
<b>Cardiology</b>																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Angina pectoris																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension (high blood pressure)																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Cardiac arrhythmia																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease																																																																																																																																			
<b>Pulmonology</b>																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	History of tobacco use																																																																																																																																			
		Current use <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease (emphysema)																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	History of tuberculosis (TB) disease																																																																																																																																			
		Treated <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																			
		Current TB symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																			
<b>Neurology and Psychiatry</b>																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	History of stroke, with current impairment																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Major impairment in learning, intelligence, self care, memory, or communication																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Major mental disorder (including major depression, bipolar disorder, schizophrenia, mental retardation)																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Use of drugs other than those required for medical reasons																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Addiction or abuse of specific* substance (drug)																																																																																																																																			
		*amphetamines, cannabis, cocaine, hallucinogens, inhalants, opioids, phencyclidines, sedative-hypnotics, and anxiolytics																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Other substance-related disorders (including alcohol addiction or abuse)																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Ever taken action to end your life																																																																																																																																			
No	Yes	Ever caused SERIOUS injury to others, caused MAJOR property damage or had trouble with the law because of medical condition, mental disorder, or influence of alcohol or drugs																																																																																																																																			
<b>Obstetrics and Sexually Transmitted Diseases</b>																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy Fundal height _____ cm																																																																																																																																			
		Last menstrual period Date (mm-dd-yyyy) _____																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted diseases, specify _____																																																																																																																																			
<b>Endocrinology and Hematology</b>																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes mellitus																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	History of malaria																																																																																																																																			
<b>Other</b>																																																																																																																																					
<input type="checkbox"/>	<input type="checkbox"/>	Malignancy, specify _____																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic renal disease																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Chronic hepatitis or other chronic liver disease																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Hansen's Disease																																																																																																																																			
		<input type="checkbox"/> Tuberculoid <input type="checkbox"/> Borderline <input type="checkbox"/> Lepromatous																																																																																																																																			
		OR <input type="checkbox"/> Paucibacillary <input type="checkbox"/> Multibacillary																																																																																																																																			
		Treated <input type="checkbox"/> Yes <input type="checkbox"/> No																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Visible disabilities (including loss of arms or legs), specify _____																																																																																																																																			
<input type="checkbox"/>	<input type="checkbox"/>	Other requiring treatment, specify _____																																																																																																																																			

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

No  Yes Applicant appears to be providing unreliable or false information, specify \_\_\_\_\_

Height \_\_\_\_\_ cm    Weight \_\_\_\_\_ kg    Visual Acuity at 20 feet: Uncorrected L 20/ \_\_\_\_\_ R 20/ \_\_\_\_\_

BP \_\_\_\_\_ / \_\_\_\_\_ (mmHg)    Heart rate \_\_\_\_\_ /min    Respiratory rate \_\_\_\_\_ /min    Corrected L 20/ \_\_\_\_\_ R 20/ \_\_\_\_\_

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

<table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%;">N*</th> <th style="width:10%;">A*</th> <th style="width:10%;">ND*</th> <th style="width:70%;"></th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>General appearance and nutritional status</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hearing and ears</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Eyes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Nose, mouth, and throat (include dental)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart (S1, S2, murmur, rub)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Breast</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lungs</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Abdomen (including liver, spleen)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Genitalia (including circumcision, infection(s))</td> </tr> </table>	N*	A*	ND*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance and nutritional status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing and ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose, mouth, and throat (include dental)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart (S1, S2, murmur, rub)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (including liver, spleen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia (including circumcision, infection(s))	<table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:10%;">N*</th> <th style="width:10%;">A*</th> <th style="width:10%;">ND*</th> <th style="width:70%;"></th> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Inguinal region (including adenopathy)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Extremities (including pulses, edema)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Musculoskeletal system (including gait)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Lymph nodes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Nervous system (including nerve enlargement)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)</td> </tr> </table>	N*	A*	ND*		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inguinal region (including adenopathy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities (including pulses, edema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal system (including gait)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (including nerve enlargement)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)
N*	A*	ND*																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	General appearance and nutritional status																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing and ears																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose, mouth, and throat (include dental)																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart (S1, S2, murmur, rub)																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen (including liver, spleen)																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitalia (including circumcision, infection(s))																																																																						
N*	A*	ND*																																																																							
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inguinal region (including adenopathy)																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities (including pulses, edema)																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal system (including gait)																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin (including hypopigmentation, anesthesia, findings consistent with self-inflicted injury or injections)																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymph nodes																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system (including nerve enlargement)																																																																						
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental status (including mood, intelligence, perception, thought processes, and behavior during examination)																																																																						

**3. Additional Testing Needed Prior to Approving Medical Clearance**

No Yes

Physical examination or laboratory results contradict medical history

Referral prior to departure If yes, provide results \_\_\_\_\_  
\_\_\_\_\_

Referral prior to departure If yes, provide results \_\_\_\_\_  
\_\_\_\_\_

**4. Follow-up Needed After Arrival**

No  Yes, within 1 week  Yes, within 1 month  Yes, within 6 months

For continuing medication, list type, dose, and frequency \_\_\_\_\_  
\_\_\_\_\_

For continuing other treatment, specify \_\_\_\_\_  
\_\_\_\_\_

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

**PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICES**

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:

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).