Case Study – Pregnant Applicant
June 30, 2026
Civil Surgeons

This scenario is purely fictional, including references to any country. The exam takes place today, so you should use the current TIs. You are completing the immigrant medical exam, and the applicant is not a refugee.

You are seeing a 27-year-old G2P1 applicant from Vietnam who is 16 weeks pregnant. Let's walk through relevant portions of the immigration medical exam for this applicant, noting any special circumstances for pregnant applicants.

You may use resources to complete this.

Q1. First, since it is early in the pregnancy and this is your first time seeing the applicant, it is hard to tell visually if she is pregnant. Should you give this applicant a pregnancy test?

A1. NO! Pregnancy tests are not part of the immigration medical exam.

Vaccinations
Q2. Based solely on this patient's age, what vaccines would this applicant be required to be up-to-date on for the US immigration medical examination? What resource would you use to determine this?

A2. Review Table 1. Based on her age (18-64 years), she is required to be up to date with Td/Tdap, Polio, MMR, Hepatitis B, Varicella, and Influenza.

Q3. Now, let's review this applicant's vaccine card. If this was actually her vaccine card, what would we need to see on it to be considered valid? CASE STUDY VACCINE CARD.pdf

A3. We would need to see valid dates including month, day, and year. Other things to look for include name, lot number, etc.

Q4. We are going to use this vaccine card to make the activity easier. Based on this applicant's vaccine card, what vaccinations would she need to receive for the US immigration medical exam if she were not pregnant and explain why by showing resources?

A4. For this applicant, if she were not pregnant, she would require:
1. Tdap since never had Tdap at 11yo
2. Varicella (not listed/not part of routine vaccine schedule in Vietnam)
3. Hepatitis B (since her last dose was at younger than 24 weeks/6 months of age)
4. Influenza (not listed) and
5. IPV (since her last dose was younger than 4 years old).

Q5. What resources did you use to make these determinations?

A5. https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-notes.html to check if the schedule matches the ACIP schedule
And https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-notes.html to check what spacing to use

Q6. Now, taking into account this applicant is pregnant, what vaccines should and shouldn't she receive?

A6. Should: Tdap or Td, Hepatitis B (since her last dose was at younger than 24 weeks or 6 months of age), and Influenza.
Should not give:

- Varicella
- IPV

Because the effects of the varicella virus on the fetus are unknown, pregnant women should not be vaccinated.
Because pregnancy is considered a Precaution for vaccination with IPV, pregnant women should not be vaccinated for the immigration medical exam.

Q7. Which blanket waiver would you use for varicella? Which for IPV?

A7. Contraindicated for both. Even though IPV is a precaution, it is the best way we have to document.

Q8. The original applicant's husband is also getting an immigrant medical exam, and needs varicella. Can he use his wife's pregnancy as a contraindication for vaccination against varicella?

A8. No! For persons without evidence of immunity, having a pregnant household member is not a contraindication for vaccination.

Q9. For our original 27 year old pregnant applicant, is Tdap or Td preferred in this instance?

A9. Given she is previously immunized but due for a Tdap booster (did not receive at age 11), then Tdap must be given at the time of the exam.

Q10. What options does she have if she does not want to get Tdap before the recommended window of 27-36 weeks gestation?

A10. She can delay completing the exam until she is in that window.

Q11. What if the applicant was completely unimmune for tetanus?

A11. She would need a three dose primary series (2 Td and 1 Tdap). While it is preferred for the Tdap dose to be first, it can be substituted for any of the Td doses. Therefore, if she preferred to wait until the 3rd trimester to get the dose of Tdap, she could receive the Td now. Given the preferred timing of Tdap in pregnancy is 27-36 weeks per ACIP.

Q12. What website can you use to find out that she needs the three dose primary series?

A12. You can find that under routine vaccination in https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-notes.html

Q13. Are there any other required vaccines for this age group that would be contraindicated in pregnancy? (*Hint* this applicant is already vaccinated against this).

A13. MMR
Routine pregnancy testing of women of childbearing age before administering a live-virus vaccine is not recommended. However, applicants should be counseled to practice safe sex for 4 weeks after vaccination. MMR or varicella vaccination during pregnancy should not be considered a reason to terminate pregnancy.

Q15. Are there any issues to administering Hepatitis B to this applicant? Where would you find this information?

A15. If not already vaccinated with hepatitis B vaccine (HepB), pregnant women **should** be vaccinated with HepB in pregnancy, since all adults 19 through 59 years of age are recommended to receive HepB vaccination.

- Note: Heplisav-B and PreHevbrio are **not** recommended in pregnancy due to lack of safety data in pregnant women
- Engerix-B or RecombivaxHB can be used but RecombivaxHB has widely been discontinued

TB Screening
Q1. Does this applicant require TB screening?
A1. Yes, all adult applicants require some type of TB screening. All applicants of any age must have a medical history and physical exam to screen for TB. Applicants 2 years and older must receive an IGRA.

Q2. She brings you a past positive IGRA. Can you use this?
A2. Yes, you can use a past positive IGRA.

Q3. She also brings you a chest x-ray from three years ago that was normal. What are your next steps?
A3. You must order a chest x-ray, based on the past positive IGRA result. Regardless of the time of last chest x-ray, the civil surgeon must be the one to order the chest x-ray.

Q4. Is it safe to do chest x-rays on pregnant women? If so, what is the best way to do so?

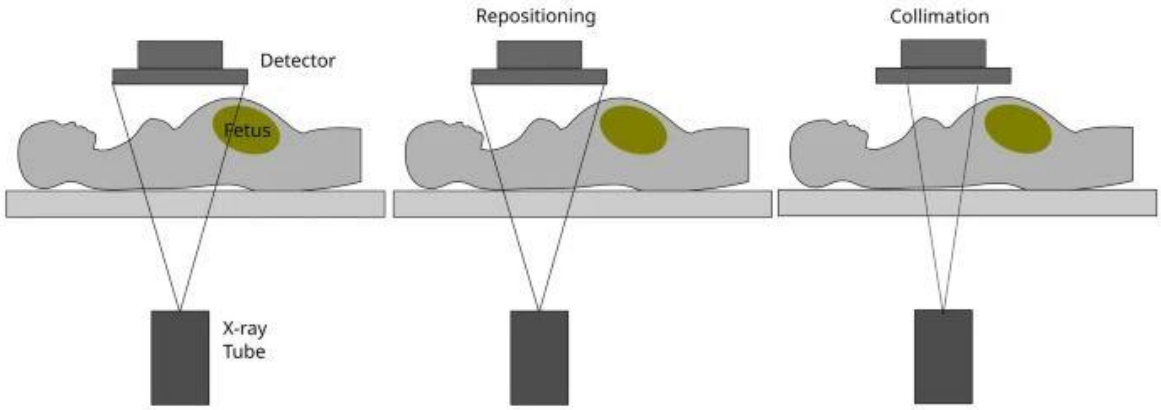
A4. Yes, it is safe to do chest x-rays on pregnant women.

- Typical chest x-ray dose is 0.01 rad.
- Approximate fetal dose from chest x-ray is <0.001 rad.
- In utero deterministic effects are not seen at doses <5 rad at any gestational age.

- X-Rays, Pregnancy and You | FDA
- Radiation Dose from X-Ray and CT Exams

Period (age)		Dose / deterministic effects		
Menstrual/gestational	Embryonic	< 50 mGy	50–100 mGy	> 100 mGy
0–2 weeks	Prior to conception	None	None	None
3–4 weeks	1–2 weeks	None	Probably none	Possible spontaneous abortion
5–10 weeks	3–8 weeks	None	Potential effects uncertain and too subtle to be clinically detectable	Possible malformations, increasing in probability as doses increase
11–17 weeks	9–15 weeks	None	Potential effects uncertain and too subtle to be clinically detectable	Risk of cognitive deficits becoming more frequent and more severe as doses increase
18–27 weeks	16–25 weeks	None	None	Deficits in intelligence not detectable at diagnostic doses
> 27 weeks	> 25 weeks	None	None	None are applicable to diagnostic medicine

- Appropriate film acquisition technique and collimation should be used.



Partial irradiation of the conceptus (left) can be avoided by repositioning (center) or collimation of the field of view (right), or a combination of the two

Q5. Should lead shielding be used when imaging a potentially pregnant or known pregnant patient?

A5. Per the American College of Radiology, the use of shielding has been shown to potentially increase internal scatter and, therefore, likely radiation dose to the fetus. Also, if any part of the shield is within the radiographic field of view, this could result in increased overall radiation dose to the patient and fetus. In the past, the use of shielding was optional but not required. Considering new data, however, the use of protective shielding for the pelvis, when it is outside the field of view, is not recommended. **This recommendation should not supersede local laws and guidelines.**

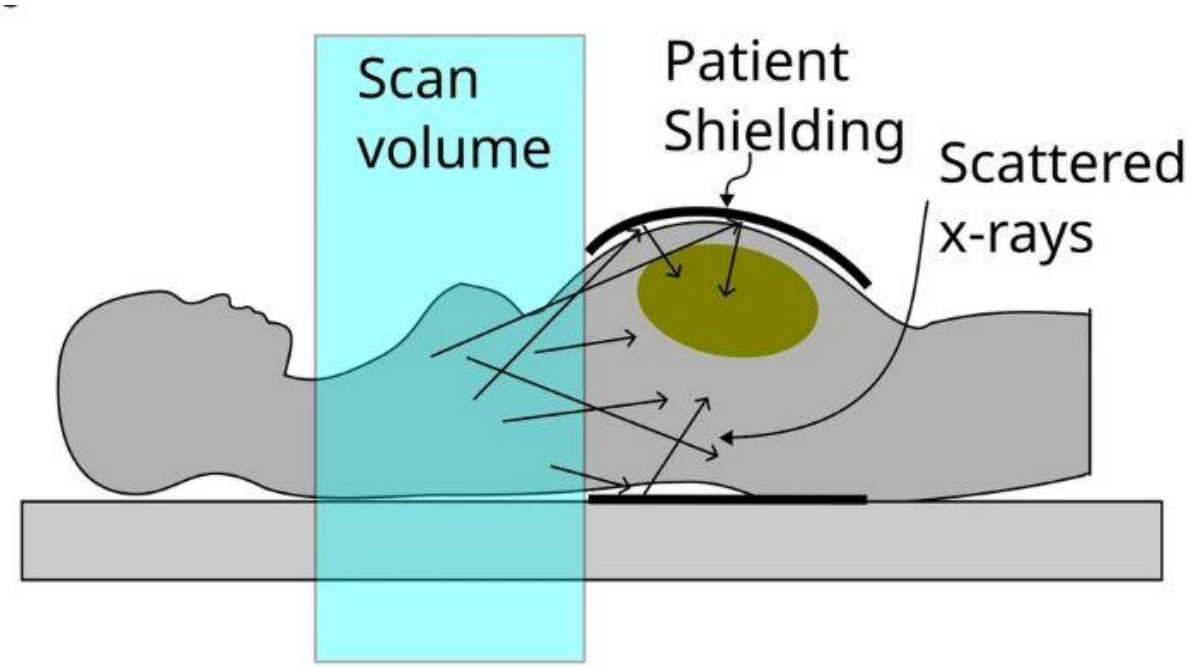


Illustration of internal scattered radiation which is not reduced by external patient shielding, and may cause backscatter from the material that would have otherwise escaped

Q6. If local facilities do not require lead shielding, but patients expect it, what is the best way to implement a no-shielding practice?

A6. Health care professionals and patients must feel comfortable with the care provided in an imaging department. To ensure this:

- Upon greeting a patient and explaining the procedure, a technologist may wish to inform the patient of the no-shielding policy and its rationale.
- Patients should be given the opportunity to ask questions and express concerns.
- Information in the form of posters or pamphlets may be helpful.

Technologists should have the authority and discretion to use shielding if a patient is extremely anxious and feels that shielding would provide a significant psychological benefit to the patient.

Q7. The applicant does not want to get the x-ray while pregnant. Can she be exempt?

A7. No, there is not an exemption of this type. Applicants who are pregnant may postpone the required chest x-ray (and completion of medical examination) until after pregnancy but are required to have a chest x-ray if they meet criteria for it.

Q8. What are some talking points you can use to counsel the applicant on the importance of continuing TB testing and getting an accurate TB diagnosis while pregnant?

A8. Untreated tuberculosis (TB) disease represents a greater hazard to a pregnant woman and her fetus than does its treatment. All applicants diagnosed with active TB disease must be treated

regardless of pregnancy status. You can consult the COE for any of these cases and must consult for drug resistant TB.

- Infants born to women with untreated TB may be of lower birth weight than those born to women without TB and, in rare circumstances, the infant may be born with TB.
- Although the drugs used in the initial treatment regimen for TB cross the placenta, they do not appear to have harmful effects on the fetus.
- Even if she had a normal chest x-ray in the past, she may have now developed active TB and she will need a chest x-ray to check.
- Most TB infections in the US started out as LTBI.
- The civil surgeon cannot finalize the immigration medical exam until TB status is known.

Syphilis

Q1. In the syphilis screening, the nontreponemal test is positive. What are some potential considerations for a pregnant applicant with a positive nontreponemal test?

A1. False positive nontreponemal test results can be associated with pregnancy. Positive/reactive nontreponemal tests must always receive a treponemal test.

Q2. What are some other conditions that may be associated with false positive nontreponemal test results?

A2. Other infections (e.g., HIV, tuberculosis, hepatitis, malaria), autoimmune conditions (e.g., systemic lupus, rheumatoid arthritis), vaccinations (e.g., smallpox, MMR), injection drug use, pregnancy, and older age.

Q3. The treponemal test was also reactive and she has syphilis! She is allergic to penicillin. What are your next steps?

A3. There are no proven alternatives to injectable penicillin regimens available for pregnant women. She should be desensitized and treated with penicillin.

Q4. When can she be made Class B for syphilis?

A4. After completing treatment.