THE UNITED METHODIST CHURCH
MEDICAL REPORT OF MINISTERIAL CANDIDATE

The physician will decide which tests are necessary to present a practical medical history.

PART 1: MEDICAL HISTORY REPORT

To be completed by the candidate

Name ____ Date of Birth______________________

Address ______________________________________City ______________________State______ZIP ___________

Marital Status __________________ Number of Children ________________

1. Check if you have ever had:

Arthritis	Diabetes	High blood pressure	Poliomyelitis
Asthma	Epilepsy	Kidney Trouble	Rheumatic fever
Cancer	Heart trouble	Peptic Ulcer	Tuberculosis

2. Check if any member of your family has ever had:

Arthritis	Diabetes	High blood pressure	Poliomyelitis
Asthma	Epilepsy	Kidney Trouble	Rheumatic fever
Cancer	Heart trouble	Peptic Ulcer	Tuberculosis

Explain____

3. What vaccinations or inoculations have you had? Give dates____

____

4. Have you ever had an electrocardiogram? If so, give date and attending physician: _____________________

____

5. Have you ever had a serious accident or operation? Explain____

____

6. Have you any impairment of sight?___________________________________ Hearing?__________________________

7. If your weight has changed in the past two years, state approximate loss__________________ gain__________________

8. Have you ever been rejected for life insurance? ____

9. Have you ever received treatment for alcohol or drug habit?____

10. Do you smoke?__________ How long?__________________ How much?______________________________

11. Have you ever been under observation or treatment in any hospital or sanitarium for a physical or nervous condition?____
Explain____

____

The above statements are true and accurate to the best of my knowledge.

Signature ____ Date__________________

PART II: MEDICAL EXAMINER'S REPORT

To be completed by the physician

1. General appearance ______________________________

2. Personal hygiene ______________________________

3. Height ______________ Weight ______________

4. Temperature ______________ Pulse ______________ Blood pressure ______________
(give readings before and after exercise)

5. Vision ______________________________

6. Hearing ______________________________

7. Condition of mouth and throat ______________________________
   Pharynx ______________ Tonsils ______________
   Mucous Membranes ______________ Teeth ______________
   Tongue ______________ Gums ______________

8. Evidence of goiter, enlarged glands, or other tumors ______________________________
____

9. Evidence of varicosity ______________________________

10. Evidence of disease or abnormalities of ______________________________
    Heart ______________________________
    Lungs ______________________________
    Thorax ______________________________
    Spine ______________________________
    Genitalia ______________________________

11. Evaluate the nervous and mental condition ______________________________
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Laboratory Tests
   Urine ______________ Chest X-ray ______________
   Complete blood count (hemoglobin, PC, white count) ______________
   Pap smear ______________
   Electrocardiogram (base line EKG) ______________
   Other ______________

SUMMARY OF FINDINGS AND RECOMMENDATIONS:

Name of Physician (print or type) ______________________________
Address ______________________________
Signature of Physician ______________ Date ______________

OFFICIAL FORM FROM DIVISION OF ORDAINED MINISTRY