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 ____________________
____

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