

# 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 \_\_\_\_\_