

THE UNITED METHODIST CHURCH
MEDICAL REPORT OF MINISTERIAL CANDIDATES

Part I: MEDICAL HISTORY REPORT

To be completed by the candidate

Name _____ Date of Birth _____

Address _____

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 ever had 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 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_____Gum_____
 - 8. Evidence of goiter, enlarged glands, or other tumors_____
 - 9. Evidence of varicosity_____Hernia_____
 - 10. Evidence of disease or abnormalities of:
 - Heart_____
 - Lungs_____
 - Thorax_____
 - Spine_____
 - Genitalia_____
 - 11. Evaluate nervous and mental condition_____
- Laboratory Tests (required)
- Pap Smear (for all women)_____Mammogram_____
 - PSA (for men over 50)_____Cholesterol_____
 - Fasting Blood Sugar_____

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Name of physician_____

Type or print

Address_____

Signature of physician_____

Date_____

Mail completed form to: **Board of Ordained Ministry**
898 Arkadelphia Road
Birmingham, AL 35204