

MEDICAL REPORT OF MINISTERIAL CANDIDATE



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 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

Name of patient: \_\_\_\_\_

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 \_\_\_\_\_ 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 \_\_\_\_\_