

**THE UNITED METHODIST CHURCH
MEDICAL REPORT OF MINISTERIAL CANDIDATE**

To the Board of Ordained Ministry:

1. Indicate which laboratory tests your board requires for completion of the medical examiner's report.
2. Indicate to the physician the address of the board officer who will receive this report.

Part I: MEDICAL HISTORY REPORT *To be completed by the candidate.*

Name _____ Date of Birth _____

Address _____
Street City State Zip

E-mail _____

Marital Status: Single, never married _____ Married, in first marriage _____ Married, in second or more _____
Widowed _____ Separated _____ Divorced _____

Number of children _____

- | | | | | |
|--|------------------------------------|--|--|--|
| 1. Check if you have ever had: | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Poliomyelitis |
| | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Rheumatic fever |
| | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> Tuberculosis |
| 2. Check if any member of
your family has ever had: | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Poliomyelitis |
| | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Rheumatic fever |
| | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Peptic ulcer | <input type="checkbox"/> 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? Yes No Hearing? Yes No

7. If your weight has changed in the past two years, state approximate loss/gain. _____

8. Have you ever been rejected for life insurance? Yes No

9. Have you ever received treatment for alcohol or drug habit? Yes No

10. Do you smoke? Yes No If yes, how long? _____ How much? _____

11. Have you ever been under observation or treatment in any hospital or sanitarium for a physical or nervous condition?
 Yes No 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
Temperature _____ Pulse _____ Blood Pressure _____ 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) _____ Date _____

Address _____
Street City State Zip

Signature of Physician _____

OFFICIAL FORM FROM DIVISION OF ORDAINED MINISTRY, GBHEM