THE ______________________ 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 examiners 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:
☐ 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? ☐ Yes ☐ No Hearing? ☐Yes ☐ No

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

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

9. Have your 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

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Name of physician (Type or print) ______________________________ Date ________________

Address ____
Street City State Zip

Signature of Physician ____

______________________ **OFFICIAL FORM FROM DIVISION OF ORDAINED MINISTRY,** ________________

Please send copy of this form to:____