

Medical Report Form
New England Conference of The United Methodist Church
Board of Ordained Ministry

To the Physician:

1. Ordained ministry often requires 60 hours or more of work per week. Segments of this work are potentially emotionally stressful. Are there any indications that this person would be unable to do such work? If so, please indicate them on this form, or use an additional page if needed.

2. Please return this form to: Susan Evans, Registrar
PO Box 709
Londonderry, NH 03053-0709

Part 1: Medical History Report
(To be completed by the individual before giving form to physician)

Name: _____ Date of Birth: _____

Address: _____

Marital Status: _____ Number of Children: _____

1. Check if you have ever had:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Cancer
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Poliomyelitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes

2. Check if any member of your family has ever had:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Heart trouble	<input type="checkbox"/> Peptic ulcer	<input type="checkbox"/> Cancer
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Poliomyelitis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Kidney trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Diabetes

Explain who had these illnesses: _____

3. What vaccinations or inoculations have you had? Give dates _____

4. Have you ever had an electrocardiogram? If so, give date and name of attending physician: _____

5. Have you ever had a serious accident or operation? Explain _____

6. Have you any impairment of sight? _____ of hearing? _____

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

8. Have you ever been rejected for life insurance? _____

9. Have you ever received treatment for alcohol or drug habits, or any form of chemical dependency?

When and where? _____

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, complete, and accurate to the best of my knowledge.

Signature: _____ Date: _____

Part 2: Medical Examiner's Report (to be completed by the physician) Date form completed: _____

1. General appearance _____

2. Personal hygiene _____

3. Height _____ Weight _____ Temperature _____

4. Pulse before exercise _____ After exercise _____
Blood Pressure before exercise _____ After exercise _____

5. Vision _____ Hearing _____

6. Condition of mouth and throat: _____
Pharynx _____ Tonsils _____
Mucous membranes _____ Teeth _____
Tongue _____ Gums _____

7. Evidence of goiter, enlarged glands, or other tumors _____

8. Evidence of varicosity _____ Hernia _____

9. Evidence of disease or abnormalities of:
Heart _____
Lungs _____
Thorax _____
Spine _____
Genitalia _____

10. Evaluate nervous and mental condition: _____

Laboratory Tests: (indicate if within normal limits, if abnormal, please specify areas of abnormality)

Urine _____
Chest X-ray _____
Complete blood count (Hemoglobin, PCV, white count) _____
Pap smear (if applicable) _____
Electrocardiogram (base line EKG) _____
Other _____

Summary of Findings and Recommendations

_____ This person **IS** medically capable of handling work which often requires 60 hours or more of work per week, segments of which are potentially emotionally stressful.

_____ This person **IS NOT** medically capable of handling work which often requires 60 hours or more of work per week, segments of which are potentially emotionally stressful.

Other major findings: _____

Name of Physician (type or print) _____

Address of Physician _____

Physician's Signature _____ Date of exam _____