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:
□ 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 _____

Form 103/2009

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