

# THE UNITED METHODIST CHURCH MEDICAL REPORT OF MINISTERIAL CANDIDATE

1. The NC Conference defers to the physician to determine which lab tests are needed based on age, gender, history, etc.
2. The candidate must complete the front (Part #1) of this report; the physician must complete the back (Part #2)

## PART I MEDICAL HISTORY REPORT (To be completed by the candidate)

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

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 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 weight gain/loss. \_\_\_\_\_

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 \_\_\_\_\_

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. \_\_\_\_\_ 6. Hearing \_\_\_\_\_

7. Condition of mouth and throat \_\_\_\_\_ Tonsils \_\_\_\_\_ Pharynx \_\_\_\_\_

Mucous Membranes \_\_\_\_\_ Tongue \_\_\_\_\_ Teeth \_\_\_\_\_ 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 \_\_\_\_\_

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 (Print or Type) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Signature of Physician \_\_\_\_\_

**PHYSICIAN, PLEASE RETURN REPORT TO:**  
Linda Bourey  
N.C. Conference of UMC  
700 Waterfield Ridge Place  
Garner, NC 27529