

EPC-UMC BOARD OF ORDAINED MINISTRY

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 _____

Marital Status _____ Number of Children _____

1. Check 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? _____ Hearing? _____

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

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

9. Have you ever received treatment for an alcohol or drug habit? _____

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 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 _____
(Give readings before and after exercise)
- 4. Temperature _____ Pulse _____ Blood Pressure _____
Temperature _____ Pulse _____ Blood Pressure _____
- 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

- Urine _____ Chest X-ray _____
- Complete blood count (hemoglobin, MCV, white count) _____
- Pap smear _____
- Electrocardiogram (base line EKG) _____
- Other _____

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Name of physician _____
(Type or print)

Address _____

Signature of physician _____

Date _____

**Send to BOOM – Registrar
Retain a copy for your records.**