THE UNITED METHODIST CHURCH
MEDICAL REPORT OF MINISTERIAL CANDIDATE

To: The Board of Ordained Ministry, South Carolina Conference

1. Complete Physical with laboratory tests is required by Board for completion of the medical examiner's report.
2. Indicate to the physician the address of the District Office 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*

Patients Name_____

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 (all women)_____ Mammogram (all women)_____
PSA (for men over 50) _____ Cholesterol _____
Fasting Blood Sugar _____

SUMMARY OF FINDINGS AND RECOMMENDATIONS

_____
_____
_____

Name of physician: (Type or Print Name) _____Date: _____

Address: _____
Street City State Zip

Signature of physician: _____ Date: _____

OFFICIAL FORM FROM DIVISION OF ORDAINED MINISTRY, GBHEM