

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 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: _____

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