

**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 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 _____

Form 103/2004

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

BOM Handbook, Chapter 3, BOM Registrars Form 103/2004