THE UNITED METHODIST CHURCH
MEDICAL REPORT OF MINISTERIAL CANDIDATE

Part I: MEDICAL HISTORY REPORT *To be completed by the candidate.*

Name _____ Date of Birth _____

Address _____
Street City State Zip

Email _____

Marital Status: Single, never married _____ Married, in first marriage _____ Married, in second or more _____
Widow _____ 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 _____

Mail Medical Report to:
Rio Texas Conference UMC
16400 Huebner Rd., San Antonio, TX 78248
210-408-4500 Ext. 530/210-408-4481 Fax
Attn: Alicia Leyva

PART II: MEDICAL EXAMINER'S REPORT *To be completed by the physician.*

Patient's Name (Candidate to Ministry): _____ DOB: _____

1. General Appearance _____
2. Personal Hygiene _____
3. Height _____ Weight _____
4. 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 (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 _____

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