



Institute for Continuing Theological Education
Pontifical North American College

00120 Vatican City State
Europe

Medical History and Physician's Report

(Applicant completes pages 1-to-3 before taking this form to physician)

Last Name	First Name	Middle Initial
Diocese / Religious Community		Social Security Number
Medical Insurance Provider		Policy Number
Type / Nature of Policy		Date of Expiration (MM/DD/YY)

Personal Medical Background

1) *Have you ever been hospitalized or had surgery?* Yes No If YES, list the following:

Reason for Hospitalization	Year
Type of Surgery	Year

2) *Have you ever been in a serious accident?* Yes No

If YES, give the date and describe the medical findings:

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3) *Have you ever had an allergic reaction to any medication(s)?* Yes No

If YES, please list the generic name of the medication(s) and its purpose:

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4) Do you take any medication(s) regularly? Yes No

If YES, please list the generic name of the medication(s) and its purpose:

5) Do you have allergies (seasonal, food, bee sting, other)? Yes No

If YES, please describe:

PERSONAL HISTORY

6) Please answer all questions. Add applicable comments on all YES answers on a supplemental sheet.

Have you had:	Yes	No	Age	Have you had:	Yes	No	Age
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	___	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	___
Frequent Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	___	Measles	<input type="checkbox"/>	<input type="checkbox"/>	___
Albumin / Sugar in Urine	<input type="checkbox"/>	<input type="checkbox"/>	___	Depression	<input type="checkbox"/>	<input type="checkbox"/>	___
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	___	Skin Rashes / Sores	<input type="checkbox"/>	<input type="checkbox"/>	___
Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	___	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	___
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	___	Frequent Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	___
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	___	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	___
Stomach / Intestinal Problem	<input type="checkbox"/>	<input type="checkbox"/>	___	Infectious Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	___
High or Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	___	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	___
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	___	Elevated Cholesterol Level	<input type="checkbox"/>	<input type="checkbox"/>	___
Rectal Problem / Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	___	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	___
Gallbladder Disease / Gallstone	<input type="checkbox"/>	<input type="checkbox"/>	___	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	___
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	___	Pain / Pressure in Chest	<input type="checkbox"/>	<input type="checkbox"/>	___
Recurrent Urinary Infection	<input type="checkbox"/>	<input type="checkbox"/>	___	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	___
Prostatitis / Epididymitis	<input type="checkbox"/>	<input type="checkbox"/>	___	Palpitations (Heart)	<input type="checkbox"/>	<input type="checkbox"/>	___
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	___	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	___
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	___	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	___
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	___	Recurrent Colds	<input type="checkbox"/>	<input type="checkbox"/>	___
Neuritis / Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	___	"Trick" Knee, Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	___
Recurrent Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	___	Recurrent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	___
Arthritis / Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>	___	Deviated Septum	<input type="checkbox"/>	<input type="checkbox"/>	___
Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	___	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	___
Peptic Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	___	Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	___
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	___	Tumor, Cyst	<input type="checkbox"/>	<input type="checkbox"/>	___
Hearing Problem	<input type="checkbox"/>	<input type="checkbox"/>	___	Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	___
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	___	Frequent Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	___
ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>	___	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	___
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	___	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	___
Fevers / Sweats	<input type="checkbox"/>	<input type="checkbox"/>	___	Tics	<input type="checkbox"/>	<input type="checkbox"/>	___
Other Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	___	Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	___
Weakness / Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	___	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	___
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	___	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	___
Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	___	Tonsillectomy / Adenoidectomy	<input type="checkbox"/>	<input type="checkbox"/>	___
Hernia Repair	<input type="checkbox"/>	<input type="checkbox"/>	___	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	___
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	___	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	___
Head Injuries with Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	___				

7) Do you wear corrective lenses? Yes No

If YES, please indicate prescription:		
Left	Right	Date of Last Vision Exam (MM/YY)

8) Have you ever received blood transfusions or blood products? Yes No

If YES, please explain:

9) Are you currently taking any medications? (Include any over-the-counter medications)

Check conditions and indicate medications:

Allergies <input type="checkbox"/>	Cough <input type="checkbox"/>	Headaches <input type="checkbox"/>	Neurological Disorder <input type="checkbox"/>
Colds <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Indigestion <input type="checkbox"/>	ADD <input type="checkbox"/>
Constipation <input type="checkbox"/>	Seizure Disorder <input type="checkbox"/>	Insomnia <input type="checkbox"/>	Depression <input type="checkbox"/>
Medications used regularly:		Medications used occasionally:	

Immunizations

	Date (MM/YY)		Date (MM/YY)
Small Pox <input type="checkbox"/> Yes <input type="checkbox"/> No		Tetanus <input type="checkbox"/> Yes <input type="checkbox"/> No	
Cholera <input type="checkbox"/> Yes <input type="checkbox"/> No		Poliomyelitis <input type="checkbox"/> Yes <input type="checkbox"/> No	
Typhoid <input type="checkbox"/> Yes <input type="checkbox"/> No		Tuberculin Test <input type="checkbox"/> Yes <input type="checkbox"/> No	

Family History

	Age	State of Health	Occupation	Cause of Death (if applicable)
Father				
Mother				
Brothers:				
Sisters:				

Have any of your relatives ever had:	Yes	No	Relationship	Have any of your relatives ever had:	Yes	No	Relationship
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Schizophrenia / Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____		<input type="checkbox"/>	<input type="checkbox"/>	_____

Physical Examination

Examining Physician: Please review the applicant's history and complete the following pages.

Please comment on all positive answers and indicate the following:

O=Negative N=Normal X=Not Examined

GENERAL COMMENTS:

Heart

Blood Pressure		Heart Rate		Heart Rhythm	
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Eyes

	Near	Distant
Uncorrected Vision		
Corrected vision		
Other comments regarding vision:		

Ears	
Nose	
Throat	
Face	
Mouth	
Chest (Excursions)	
Neck	
Heart	
Skin	
Abdomen, Inguinal, Femoral	
Hernia	
Back and Spine	
Arms	
Legs	
Neuromuscular	
Genitourinary	
Rectal	
Prostate	
Genitalia	
Musculoskeletal	
Metabolic/Endocrine	
Neuro-psychiatric	
Gastrointestinal	
Hearing	

Height (inches)		Weight (pounds)		Overweight		Underweight	
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Recommendations for physical activity (PE, intramurals, sports):

Unlimited		Limited	
Please explain:			

Do you have any recommendations regarding the care of this patient? Yes No

Please explain:

Is the applicant now under treatment for any medical or emotional condition? Yes No

Please explain:

Is there loss or seriously impaired function of any organ? Yes No

Please explain:

Laboratory Analysis

*The following laboratory work needs to be completed. * Please attach a copy of the lab results. Also, you are asked to indicate and explain the significance of the results in the space provided..*

CBC	
Chemistry Profile (e.g. SMA)	
HIV Antibody	
Urinalysis	

Additional Remarks or Comments by examining Physician

Patient's Present Health Condition:

Are there any restrictions to medicines, diet, and physical exercise? Yes No

If YES, please explain:

Does the applicant's past medical history indicate anything significant in view of his expected living and continuing education in Rome over the next few months? Yes No

If YES, please explain:

Physician's Information

Name (please print)		Telephone	
Address			
City	State/Province	Country	Zip/Post Code

Physician's Signature _____ Date _____