# *Pontifical North American College*

## MEDICAL HISTORY AND PHYSICIAN'S REPORT

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

| Last Name | First Name | Middle Initial | Date |
|---|---|---|---|
| | | | |

| Sponsoring Diocese | 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: |
|---|
| |

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: |
|---|
| |

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

| If YES, please describe: |
|---|
| |

## PERSONAL HISTORY

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

6) Do you wear corrective lenses? ☐ Yes ☐ No

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

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

| If YES, please explain: |
|---|
| |

8) Are you currently taking any medications? (Include any over-the-counter medications)
Check conditions and indicate medications:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Allergies | ☐ | Cough | ☐ | Headaches | ☐ | Neurological Disorder | ☐ |
| Colds | ☐ | Diabetes | ☐ | Indigestion | ☐ | ADD | ☐ |
| Constipation | ☐ | Seizure Disorder | ☐ | Insomnia | ☐ | Depression/Anxiety | ☐ |

| Medications used regularly: | Medications used occasionally: |
|---|---|
| | |

## IMMUNIZATIONS

| | Yes | No | Date (MM/YY) | | Yes | No | Date (MM/YY) |
|---|---|---|---|---|---|---|---|
| Tdap | ☐ | ☐ | | Varicella | ☐ | ☐ | |
| Poliomyelitis | ☐ | ☐ | | COVID-19 | ☐ | ☐ | |
| MMR | ☐ | ☐ | | Tuberculin Test | ☐ | ☐ | |
| Hepatitis B | ☐ | ☐ | | Declined immunizations | ☐ | ☐ | |

## 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 | ☐ | ☐ | | Cancer | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | | Asthma | ☐ | ☐ | |
| Kidney Disease | ☐ | ☐ | | High Blood Pressure | ☐ | ☐ | |
| Heart Disease | ☐ | ☐ | | High Cholesterol | ☐ | ☐ | |
| Arthritis | ☐ | ☐ | | Stroke | ☐ | ☐ | |
| Stomach Disease | ☐ | ☐ | | Schizophrenia / Psychosis | ☐ | ☐ | |
| ADD/ADHD | ☐ | ☐ | | | ☐ | ☐ | |

# 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: | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| Height (inches) | | Weight (pounds) | | Overweight | | Underweight | |

## HEART

| Blood Pressure | | Heart Rate | | Heart Rhythm | |
|---|---|---|---|---|---|

## EYES

| | Near | Distant |
|---|---|---|
| Uncorrected Vision | | |
| Corrected vision | | |
| Other comments regarding vision: | | |
| | | |

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

Recommendations for physical activity (PE, intramurals, sports):

| Unlimited | | Limited | |
|---|---|---|---|
| Please explain: | | | |
| | | | |

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

| Please explain: |
|---|
| |

Is the applicant now under treatment for any medical or psychological 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 is <u>required</u>. Please indicate and explain the significance of the results in the space provided and <u>attach a copy of the lab results</u>.**

| | |
|---|---|
| CBC | |
| Chemistry Profile | |
| Syphilis Serology | |
| HIV Antibody | |
| Urinalysis | |
| Drug testing | |
| DNA Test* (for biological maleness) | |

***DNA test possibilities: Karyotype Analysis, FISH Report, etc.**

## 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 studying in Rome over the next few years? ☐ 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:** _____