



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)

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	
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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 required. Please indicate and explain the significance of the results in the space provided and attach a copy of the lab results.

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: _____