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| crest_lz2 | Institute for Continuing Theological EducationPontifical North American College00120 Vatican City StateEurope |  |

## **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)* |
|  |  |  |  |
| Date of Birth | age |  |
| mo | day | year |

##### 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 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 | 🞎 | 🞎 | \_\_\_ | Hypoglycemia | 🞎 | 🞎 | \_\_\_ |
| Frequent Anxiety | 🞎 | 🞎 | \_\_\_ | Measles | 🞎 | 🞎 | \_\_\_ |
| Albumin / Sugar in Urine | 🞎 | 🞎 | \_\_\_ | Depression | 🞎 | 🞎 | \_\_\_ |
| German Measles | 🞎 | 🞎 | \_\_\_ | Skin Rashes / Sores | 🞎 | 🞎 | \_\_\_ |
| Obsessive Compulsive Disorder | 🞎 | 🞎 | \_\_\_ | Mumps | 🞎 | 🞎 | \_\_\_ |
| Eczema | 🞎 | 🞎 | \_\_\_ | Frequent Nausea / Vomiting | 🞎 | 🞎 | \_\_\_ |
| Chicken Pox | 🞎 | 🞎 | \_\_\_ | Psoriasis | 🞎 | 🞎 | \_\_\_ |
| Stomach / Intestinal Problem | 🞎 | 🞎 | \_\_\_ | Infectious Mononucleosis | 🞎 | 🞎 | \_\_\_ |
| High or Low Blood Pressure | 🞎 | 🞎 | \_\_\_ | Hernia | 🞎 | 🞎 | \_\_\_ |
| Diabetes | 🞎 | 🞎 | \_\_\_ | Elevated Cholesterol Level | 🞎 | 🞎 | \_\_\_ |
| Rectal Problem / Hemorrhoids | 🞎 | 🞎 | \_\_\_ | Rheumatic Fever | 🞎 | 🞎 | \_\_\_ |
| Gallbladder Disease / Gallstone | 🞎 | 🞎 | \_\_\_ | Heart Murmur | 🞎 | 🞎 | \_\_\_ |
| Jaundice | 🞎 | 🞎 | \_\_\_ | Pain / Pressure in Chest | 🞎 | 🞎 | \_\_\_ |
| Recurrent Urinary Infection | 🞎 | 🞎 | \_\_\_ | Shortness of Breath | 🞎 | 🞎 | \_\_\_ |
| Prostatitis / Epididymitis | 🞎 | 🞎 | \_\_\_ | Palpitations (Heart) | 🞎 | 🞎 | \_\_\_ |
| Kidney Stones | 🞎 | 🞎 | \_\_\_ | Pneumonia | 🞎 | 🞎 | \_\_\_ |
| Chronic Cough | 🞎 | 🞎 | \_\_\_ | Varicose Veins | 🞎 | 🞎 | \_\_\_ |
| Frequent Urination | 🞎 | 🞎 | \_\_\_ | Recurrent Colds | 🞎 | 🞎 | \_\_\_ |
| Neuritis / Neuralgia | 🞎 | 🞎 | \_\_\_ | “Trick” Knee, Shoulder | 🞎 | 🞎 | \_\_\_ |
| Recurrent Sinus Infections | 🞎 | 🞎 | \_\_\_ | Recurrent Headaches | 🞎 | 🞎 | \_\_\_ |
| Arthritis / Arthralgia | 🞎 | 🞎 | \_\_\_ | Deviated Septum | 🞎 | 🞎 | \_\_\_ |
| Migraine Headaches | 🞎 | 🞎 | \_\_\_ | Bursitis | 🞎 | 🞎 | \_\_\_ |
| Peptic Ulcer | 🞎 | 🞎 | \_\_\_ | Back Problems | 🞎 | 🞎 | \_\_\_ |
| Seizure Disorder | 🞎 | 🞎 | \_\_\_ | Tumor, Cyst | 🞎 | 🞎 | \_\_\_ |
| Hearing Problem | 🞎 | 🞎 | \_\_\_ | Dyslexia | 🞎 | 🞎 | \_\_\_ |
| Cancer | 🞎 | 🞎 | \_\_\_ | Frequent Ear Infections | 🞎 | 🞎 | \_\_\_ |
| ADD / ADHD | 🞎 | 🞎 | \_\_\_ | Anemia | 🞎 | 🞎 | \_\_\_ |
| Hoarseness | 🞎 | 🞎 | \_\_\_ | Immune Deficiency | 🞎 | 🞎 | \_\_\_ |
| Fevers / Sweats | 🞎 | 🞎 | \_\_\_ | Tics | 🞎 | 🞎 | \_\_\_ |
| Other Blood Disorder | 🞎 | 🞎 | \_\_\_ | Weight Loss / Gain | 🞎 | 🞎 | \_\_\_ |
| Weakness / Paralysis | 🞎 | 🞎 | \_\_\_ | Dizziness / Fainting | 🞎 | 🞎 | \_\_\_ |
| Asthma | 🞎 | 🞎 | \_\_\_ | Insomnia | 🞎 | 🞎 | \_\_\_ |
| Appendectomy | 🞎 | 🞎 | \_\_\_ | Tonsillectomy / Adenoidectomy | 🞎 | 🞎 | \_\_\_ |
| Hernia Repair | 🞎 | 🞎 | \_\_\_ | Epilepsy | 🞎 | 🞎 | \_\_\_ |
| Tuberculosis | 🞎 | 🞎 | \_\_\_ | Hepatitis | 🞎 | 🞎 | \_\_\_ |
| Head Injuries with Unconsciousness | 🞎 | 🞎 | \_\_\_ |  |  |  |  |
|  |  |

|  |
| --- |
| *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  | 🞎 | Cough  | 🞎 | Headaches  | 🞎 | Neurological Disorder | 🞎 |
| Colds  | 🞎 | Diabetes  | 🞎 | Indigestion | 🞎 | ADD | 🞎 |
| Constipation  | 🞎 | Seizure Disorder | 🞎 | Insomnia | 🞎 | Depression | 🞎 |
| Medications used regularly: | Medications used occasionally: |
|  |  |

**Immunizations**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Date (MM/YY) |  | Date (MM/YY) |
| Small Pox | 🞎Yes 🞎No  |  | Tetanus | 🞎Yes 🞎No  |  |
| Cholera | 🞎Yes 🞎No |  | Poliomyelitis | 🞎Yes 🞎No  |  |
| Typhoid | 🞎Yes 🞎No |  | Tuberculin Test | 🞎Yes 🞎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* | 🞎 | 🞎 | \_\_\_\_\_\_\_\_ | *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:*** |
|  |

***Heart***

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

***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 |  |

|  |
| --- |
| 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: |
|  |

**CHALLENGES of the Institute in Rome:**

(Capability rating: 1 = capable / 2 = moderately capable / 3 = incapable)

 **CAPABILITY:**

**• General:**

* Four hours/day classes; five days/week 1 2 3
* One-two hours of religious commitment 1 2 3
* Pilgrimages & sight-seeing: varies per day (2 – 4 hours optional) 1 2 3
* Rigors of the schedule 1 2 3
* Extensive periods of city walking at times 1 2 3

(Capability rating: 1 = capable / 2 = moderately capable / 3 = incapable)

• **Mediterranean environment:**

* Allergic reaction due to high pollen count 1 2 3
* Damp environment / heating system compromised at times 1 2 3
* Sudden air pressure changes causing headaches 1 2 3
* Catacombs (40 feet underground) 1 2 3
* Hilly and cobblestone terrain 1 2 3

• **Significant cultural challenges due to American Ethnocentrism**

* Fast moving city 1 2 3
* Crowded buses 1 2 3
* Common spoken language is Itlalian 1 2 3
* Facilitating Euro currency 1 2 3
* Italian meal schedules 1 2 3
* High salt content & spices in Mediterranean food 1 2 3

**In your physical & medical assessment, would you recommend this person at this time for the program?**

 **YES**   **NO**

|  |
| --- |
| ***Physician’s Information*** |
| Name (please print) | Telephone |
|  |  |
| Address |
|  |
| City | State/Province | Country | Zip/Post Code |
|  |  |  |  |

**Physician’s Signature:**

**Date:**

I have reviewed this Medical Form for completeness and agree to release the information provided to authorized members of the Institute staff, as may required.

Applicant’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicant’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The ICTE maintains and processes all participants health information for internal use only.