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:

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:

Physician's Information

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

Physician's Signature _____ **Date**_____