DIOCESE OF COVINGTON

Office of Priestly Vocations

MEDICAL HISTORY

RETURN TO: Rev. Michael B. Norton
Vocations Promoter
Diocese of Covington
1125 Madison Ave.
Covington, KY 41011

To be completed by the applicant prior to physical examination:

Date: _____ ☐ College ☐ Pre-Theology ☐ Theology

Name: _____
Last Name First Name Middle Name

Address: _____
Complete Street Address City State Zip Code

Date of Birth: _____ Place of Birth: _____ Ethnicity: _____
MM / DD / YYYY City, State, Country

How long have you lived in the U.S.? _____ Social Security Number: _____
Years xxx – xx – xxxx

Health Insurance Company Name: _____

Policy Number: _____ Policy Holder Name: _____

Entering into: College: 1 2 3 4 Pre-Theology: 1 2 Theology: 1 2 3 4

In Case of an Emergency, Notify

Name: _____ Relationship: _____

Phone: _____ Address: _____
(xxx) xxx – xxxx Street Address City, State, Zip

Family History:
Among your blood relatives is there any history or present illness of any of the following:

	Yes	No	Relationship
1. Cancer			
2. Heart Disease			
3. High Blood Pressure			
4. Stroke			
5. Tuberculosis			
6. Diabetes			
7. Nervous or Mental Condition			
8. Asthma or Hay Fever			
9. Seizures			
10. Alcoholism			
11. Drug Abuse			

Are your Parents living? Father: _____ Mother: _____ # of Living Brothers: _____ # of Living Sisters: _____

If deceased, give relationship and cause of death: _____

To be completed by the applicant prior to physical examination:

Has your health been (circle): Good Fair Poor

If not good, explain: _____

Have you ever had or do you suspect you may have had the following: If yes, please explain:

Check Each Item	Y	N	Explain	Check Each Item	Y	N	Explain
Anemia or other blood disease				Loss of arm, leg, finger or toe			
Appendicitis, acute or chronic				Loss of memory or amnesia			
Arthritis, swollen or painful joints				Kidney disease, stones, blood in urine			
Asthma or shortness of breath				Malaria			
Boils				Meningitis			
Bone, joint or other deformity				Mononucleosis			
Chronic or frequent colds				Nervous or mental condition			
Chronic cough				Neuritis			
Cramps in legs				Pain or pressure in chest			
Diabetes				Painful or "trick" joints			
Ear, nose or throat trouble				Palpitation or pounding heart			
Eating disorder				Paralysis			
Epilepsy or seizures				Pneumonia			
Eye problems				Rheumatic Fever			
Foot trouble				Scarlet Fever			
Frequent indigestion				Severe tooth or gum trouble			
Frequent or painful urination				Sinus disease			
Gall bladder trouble or gall stones				Stomach, liver, intestine trouble			
Hay fever				Soaking sweats, night sweats			
Headaches, frequent or severe				Skin disease or rashes			
Hearing loss				Thyroid trouble			
Heart disease				Tonsillitis			
Hernia or rupture				Tuberculosis			
Hepatitis or jaundice				Tumor, growth, cyst, cancer			
High or low blood pressure				Venereal disease			
Lameness				Vertigo, dizziness, fainting			

Have you ever:	Y	N	Date(s)
Worn a brace or back support			
Been treated for alcoholism			
Been treated for drug abuse			
Bled excessively after surgery or dental work			
Lived with anyone who had tuberculosis			
Coughed up blood			
Smoked or smoke now			
Do you have a regular exercise program			
Do you wear a seat belt while driving			

Current Medical Condition(s): _____

_____

_____

Current Medication(s): _____

_____

_____

Past Hospitalizations, Surgeries: _____

_____

_____

To be completed by the Physician after having performed the Physical Exam:

Age: _____ Height: _____ Weight: _____

Build: ☐ Slender ☐ Medium ☐ Heavy ☐ Obese

Blood Pressure: Sys.: _____ Dia.: _____ Pulse: _____

Urinalysis: Albumin: _____ Sugar: _____

Hearing: Right: _____ / 15 Left: _____ / 15

Vision: Right: 20 / _____ Left: 20 / _____

Correction to: Right: 20 / _____ Left: 20 / _____

Glasses: Y N Contact Lenses: Y N Color Vision: Y N

Check each item in proper column	Normal	Abnormal	Note: Give details of each abnormality
Head, neck, face, and scalp			
Nose and sinuses			
Mouth, teeth, gingiva, and throat			
Ears-acuity, lids, pupils, motions			
Eye-acuity, lids, pupils, motions			
Lungs and chest			
Heart			
Vascular System (include varicosities)			
Abdomen and Viscere (include hernia)			
Ano-rectal and Pilonidal			
Endocrine System			
Genito-Urinary System			
Upper Extremities			
Lower Extremities (Including feet)			
Spine, other Musculo-Skeletal			
Skin and lymphatics			
Neurological System			
Psychiatric (Personality deviation, etc)			

Other Abnormalities: _____

_____

HIV: _____

VDRL: _____

Any special tests used for clinical evaluation (Blood, EKG, etc.)? _____

Medicine or allergies: _____

Is there any need for injections for allergies? ☐ Yes ☐ No Frequency? _____

NEXT PAGE IS FOR IMMUNIZATION RECORD

IMMUNIZATION RECORD TO BE COMPLETED AND SIGNED BY PHYSICIAN

Students without proof of adequate immunity face exclusion from classroom attendance during any subsequent outbreak.

1. Tetanus/Diptheria
    a. Completed primary series Mo. _____ Yr. _____
    b. Received booster within last 10 Years Mo. _____ Yr. _____
2. M.M.R. (Measles, Mumps, and Rubella) if not given as individual immunizations
    a. Dose 1 --- Immunized at 12 months or later Mo. _____ Yr. _____
    b. Dose 2 --- Received after 1/1/1980 (required) Mo. _____ Yr. _____
3. Measles (Rubeola)
    a. Had disease; confirmed by office record Mo. _____ Yr. _____
    b. Born before 1957 and considered immune Mo. _____ Yr. _____
    c. Has report of immune titer Mo. _____ Yr. _____
    d. Immunized with live measles vaccine at 12 months or later Mo. _____ Yr. _____
4. Rubella
    a. Has report of immune titer Mo. _____ Yr. _____
    b. Immunized with vaccine at 12 months or later Mo. _____ Yr. _____
5. Mumps
    a. Had disease; confirmed by office record Mo. _____ Yr. _____
    b. Immunized with vaccine at 12 months or later Mo. _____ Yr. _____
6. Polio
    a. Completed primary series Mo. _____ Yr. _____
7. Tuberculin Skin Test (All are required to have a PPD (Mantoux) skin test within the past year)
    a. Give date and results: Date: _____ Results: ☐ Positive ☐ Negative _____ mm
    b. Positive PPD – Chest X-ray required Date: _____ Result of x-ray: _____
    c. Had BCG vaccine – chest x-ray required if PPD not done: Date: _____ Result of x-ray: _____

_____

Every college freshman is required to enroll in the physical education program for two semesters. (Check One or the other)

☐ This man may participate in a program of physical education, which includes such sports as basketball, soccer, swimming, gymnastics, tennis, handball, bowling or karate.

☐ This man should be enrolled in a restricted program of physical education. I make this recommendation for this reason:

_____

Physician's name: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____

Physician's Signature: _____ Date: _____