DIOCESE OF COVINGTON

MEDICAL HISTORY



RETURN TO:

Rev. Conor Kunath Vocations Promoter Diocese of Covington 1125 Madison Ave. Covington, KY 41011

Office	of	Priestly	Vocations
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To be completed by	the applicant pri-	<u>or </u> to phys	sical examination	ation:				
Date:			college		Pre-Theology		Theology	
Name:								
Last Name			First Na	ame		Middle	e Name	
Address:								
Compl	ete Street Address		City		State	Zip Co	ode	
Date of Birth:		P	lace of Birth	:		Ethnicity:		
MM		City, State, Country						
How long have you lived in the U.S.?			Social Security Number:					
Year						$\mathbf{x}\mathbf{x}\mathbf{x} - \mathbf{x}$	xx – xxxx	
Health Insurance Co	mpany Name:							
Policy Number:		Po	olicy Holder	Name:				
Entering into:	College: 1 2 3	3 4	Pre-Th	neology:	1 2	Theology: 1	234	
In Case of an Emerg	ency, Notify							
Name:					Relatio	nship:		
Phone:								
(xxx) xxx - xx	XXX		Street Addre	SS		City, S	tate, 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? Fathe	r:	M	other:# of Living Brothers:# of Living Sisters:
If deceased, give relationship a	Ind cau	ise of	f death:

To be completed by the <u>applicant prior</u> 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	Ν	Explain	Check Each Item	Y	Ν	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	Ν	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:	Heigh	ıt:		Wei	ght:				
Build:	Slender		Medium		Heavy		Obese	;	
Blood Pressure:	Sys.:		Dia.:		P	ulse:			
Urinalysis:	Albumi	n:	S	ugar:					
Hearing: Right:		/ 1	5 Left:		/	15			
Vision:	Right: 2	0 /		Lef	t: 20 /				
Correction to:	Right: 2	,0 /		Lef	t: 20 /				
Glasses:	Y	Ν	Contac	t Len	ses:		Y	Ν	

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 (Bloc	od, EKG,	etc.)?		
Medicine or allergies:				
Is there any need for injections for allergies?		Yes	No	Frequency?
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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 immuni	izations	
	a. Dose 1 Immunized at 12 mo	onths or later	Mo	Yr
	b. Dose 2 Received after 1/1/19	980 (required)	Mo	Yr
3.	Measles (Rubeola)			
	a. Had disease; confirmed by offic	ce record	Mo	Yr
	b. Born before 1957 and considered	ed immune	Mo	Yr
	c. Has report of immune titer		Mo	Yr
	d. Immunized with live measles v	accine at 12 months or later	Mo	Yr
4.	Rubella			
	a. Has report of immune titer		Mo	Yr
	b. Immunized with vaccine at 12 r	months or later	Mo	Yr
5.	Mumps			
	a. Had disease; confirmed by offic	ce record	Mo	Yr
	b. Immunized with vaccine at 12 n	months or later	Mo	Yr
6.	Polio			
	a. Completed primary series		Mo	Yr
7.	Tuberculin Skin Test (All are required to	b have a PPD (Mantoux) skin test	within the past year)	
	a. Give date and results: Date	e:Results:	□ Positive □ Negative	mm
	b. Positive PPD – Chest X-ray req	uired Date:	Result of x-ray:	
	c. Had BCG vaccine – chest x-ray	required if PPD not done: Date:	Result of	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.

 \Box 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:		D	ate: