MEDICAL HISTORY OF APPLICANT FOR THE PRIESTHOOD

Applicant: Please fill in this form by typing in the spaces provided, and present it to your physician prior to the examination.

1. NAME

_____ _____ _____
Last Name *First Name* *Middle Name*

_____ _____ _____ _____
Home Address *City* *State* *Zip Code*

_____ _____ _____ _____ _____
Phone (incl. area code) *Birthdate (mm/dd/yyyy)* *Place of Birth* *Country of Citizenship* *Social Security #*

_____ _____
Entering Semester Term *Entering Academic Year*

2. MEDICAL INSURANCE

_____ _____ _____ _____
Name of Primary Insurance Company *Phone Number* *Policy Number* *Exp. Date*

_____ _____ _____ _____ _____
Street Address *City* *State* *Country* *Zip Code*

_____ _____ _____ _____
Name of Secondary Insurance Company *Phone Number* *Policy Number* *Exp. Date*

_____ _____ _____ _____ _____
Street Address *City* *State* *Country* *Zip Code*

3. FAMILY HISTORY

Please mark item(s) for each condition a blood relation has had:

	No	Yes	Who in your family had this?		No	Yes	Who in your family had this?
Allergies	☐	☐	_____	Diabetes	☐	☐	_____
High Cholesterol	☐	☐	_____	Nervous Disorder	☐	☐	_____
Asthma	☐	☐	_____	Heart Disease	☐	☐	_____
Kidney Disease	☐	☐	_____	Tuberculosis	☐	☐	_____
Cancer/Type	☐	☐	_____	High Blood Press.	☐	☐	_____
Mental Illness	☐	☐	_____	Other: _____	☐	☐	_____

4. GENERAL MEDICAL HEALTH AND LIFESTYLE

Please provide the following information:

4.1 Height (inches): _____ Weight (lbs.): _____

4.2 Describe your physical health (20 words or fewer):

4.3 Do you smoke? ○ No ○ Yes

If yes, what do you smoke?

☐ E-Cigarettes ☐ Cigars ☐ Cigarettes ☐ Pipe

If yes, how often or how much (e.g., times/week, packs/day)? _____

4.4 Do you use chewing tobacco or snuff? ○ No ○ Yes

If yes, how often or how much (e.g., times/week)? _____

4.5 Do you drink alcohol? ○ No ○ Yes

If yes, describe your weekly alcohol consumption:

☐ Light ☐ Moderate ☐ Heavy

4.6 Do you exercise? ○ No ○ Yes

If yes, how often do you exercise?

☐ Daily ☐ Several times/week ☐ Occasionally ☐ Never

If yes, in what type of physical exercise do you regularly engage (20 words or fewer)?

_____

4.7 Did you miss any days of school or work in the last year due to illness? ○ No ○ Yes

If yes, how many days did you miss? _____

If yes, what was the cause? _____

4.8 Has your physical activity (e.g., physical education, sports) ever been restricted because of health? ○ No ○ Yes

4.9 Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? ○ No ○ Yes

4.10 Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years (other than routine checkups)? ○ No ○ Yes

4.11 Have you had any illness or injury or been hospitalized other than already noted? ○ No ○ Yes

4.12 Have you ever used intravenous or ingestible drugs? ○ No ○ Yes

4.13 Have you ever used any illegal drugs or substances? ○ No ○ Yes

4.14 Have you had sexual contact with anyone within the past two years, outside of marriage? ○ No ○ Yes

4.15 Have you been denied life insurance, rejected by or discharged from military service, or refused employment because of your health? ○ No ○ Yes

4.16 Have you ever had any serious illness, injury, or operation not listed above? ○ No ○ Yes

4.17 Have you ever been unable to take physical education or participate in sports because of your health? ○ No ○ Yes

4.18 When is the last time you visited your dentist? _____

4.19 When is the last time you visited an eye doctor? _____

If you answered "Yes" to any of the questions above (4.8 - 4.17), please explain (70 words or fewer):

5. PERSONAL MEDICAL HISTORY

5.1 Please list any serious illnesses or hospitalizations you have had (70 words or fewer):

5.2 Please list any previous surgeries or injuries (e.g., broken bone, head injury) you have had (70 words or fewer):

5.3 Pease list all current prescription and OTC medications you are currently taking (70 words or fewer):

5.4 Please check any of the following conditions you have had:

Check each item	No	Yes	Check each item	No	Yes
ADHD	☐	☐	HIV/AIDS	☐	☐
Anxiety Disorder	☐	☐	Measles	☐	☐
Asthma	☐	☐	Mononucleosis, Infectious Mumps	☐	☐
Cancer/Leukemia	☐	☐	Severe Tooth/Gum Trouble	☐	☐
Chicken Pox	☐	☐	Sickle Cell Anemia	☐	☐
Convulsions/Seizures	☐	☐	Sexually Transmitted Infections/Diseases	☐	☐
Diabetes	☐	☐	Rheumatic Fever	☐	☐
Eating disorder	☐	☐	Rubella/German Measles	☐	☐
Heart Disease/Problems	☐	☐	Thyroid Trouble	☐	☐
Hepatitis/Jaundice	☐	☐	Tuberculosis	☐	☐
High or low blood pressure	☐	☐			

If you answered "Yes" to any of the above, please explain (70 words or fewer):

5.5 Please indicate the presence, description, and severity of any allergies you have:

	No	Yes	Description	Life-Threatening?
Drugs	☐	☐	_____	☐
Foods	☐	☐	_____	☐
Plants	☐	☐	_____	☐
Insects	☐	☐	_____	☐
Other	☐	☐	_____	☐

Do you have any question in regard to your health, family history, or other matters which you would like to discuss with a health professional?

If yes, please explain (70 words or fewer):

_____

I verify that the information provided on this form is complete and accurate to the best of my knowledge.

_____ _____

Signature of Applicant *Date*

PHYSICAL EXAMINATION OF APPLICANT FOR THE PRIESTHOOD

Examining Physician: Please review the applicant's medical history and complete the following pages.

6. VACCINATION HISTORY .

Type	Date(s)
Diphtheria, Pertussis, Tetanus Series (DPT, Dtap)	
Tetanus Booster (Dt or TD)	
Polio Series	
Meningococcal Vaccine	
Chickenpox Vaccine (Varivax)	
Hepatitis A	
Hepatitis B	

REQUIRED IMMUNIZATIONS AND TB SCREENING

Oregon State Law requires that each entering full-time student born on or after January 1, 1957, must have two doses of Measles vaccine or MMR vaccine (documented by month and year of each dose) on or after the first birthday, with a minimum of 30 days between doses.

CHECK THE TYPE OF VACCINE GIVEN	DATE GIVEN	NOTES
☐ MEASLES #1 *or* ☐ MMR		Must be on or after 1st Birthday and 1/1/1957
☐ MEASLES #2 *or* ☐ MMR		Must be at least 30 days after 1st immunization
☐ RUBELLA		If given instead of MMR, must be on or after 1st birthday and 1/1/1957.
In addition, ALL incoming students regardless of age must provide evidence of TB testing. A MANTOUX/PPD test is required (Tine test is not acceptable). If there has been a positive TB skin test in the past, a repeat test is not necessary but proof of a chest x-ray OR proof of completion of a course of TB medication must be submitted.		
MANTOUX/PPD DATE PLANTED	**DATE READ**	**RESULT**
		☐ POSITIVE ☐ NEGATIVE _____ mm induration (horiz. diam.)

7. DRUG SCREENING & BLOOD TESTS

Type of Test: 5 Panel (Amphetamines/Methamphetamine, Cocaine, Marijuana (THC), Opiates, Barbiturates, Benzodiazepines, Propoxpyphene)

☐ **Positive** ☐ **Negative**

A full blood screening for HIV, Hepatitis, illegal drug use, sexually transmitted diseases or other occult health issues is required.

8. OBSERVATIONS & RECOMMENDATIONS

8.1 Do you recommend limitations for this applicant's physical activity (PE, intramural sports): ☐ No ☐ Yes
If yes, please explain (70 words or fewer):

8.2 Do you have any recommendations regarding the care of this applicant? ☐ No ☐ Yes
If yes, please explain (70 words or fewer):

8.3 Is the applicant now under treatment for any medical or emotional condition? ☐ No ☐ Yes
If yes, please explain (70 words or fewer):

8.4 Is there loss or seriously impaired function of any organ? ☐ No ☐ Yes
If yes, please explain (70 words or fewer):

9. PHYSICIAN'S INFORMATION & CERTIFICATION

I certify that this student has received the drug screening and immunizations (or has laboratory evidence of immunity), as indicated above, as well as evidence of TB testing or completion of TB medication.

_____ _____
Last Name *First Name*

_____ _____ _____ _____ _____
Address *City* *State* *Zip Code* *Phone*

_____ _____
Physician's Signature *Date*