

## Medical Examination

Required Under TITLE III, CANON 4, Sec. 2e (“of Postulants for Holy Orders”), Under TITLE III, CANON 6, Sec. 3 (“of Ordination to Deacons”), Under TITLE III, CANON 12, Sec. 1c (“of Clergy Ordained by Bishops of Other Churches in Communion with This Church”), and Under TITLE III, CANON 22, Sec. 3b (“of the Election and Ordination of Bishops”) of the Constitution and Canons (1994) for the Government of the Episcopal Church.

Name		Date of Birth
Your Home Address		Phone Number/Fax Number
Marital Status	Children and Ages	
Notify in Case of Illness		Phone Number/Fax Number
Personal Physician	Physician's Address	Phone Number/Fax Number

Please answer all questions below “Yes” or “No”; provide full details in space at bottom for any questions answered “Yes.”

**Have You**

**Yes    No**

	Yes	No
1. Ever been rejected or paid extra money for insurance?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever received Workmen's Compensation or other disability benefits?	<input type="checkbox"/>	<input type="checkbox"/>
3. Been rejected for employment on account of any physical or mental condition?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever received prescription drugs for mental illness or substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever been a patient in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
6. Had any accidents, injuries or operations or contemplate any operation?	<input type="checkbox"/>	<input type="checkbox"/>
7. Received disability benefits or medical leave for any medical/psychiatric condition?	<input type="checkbox"/>	<input type="checkbox"/>
8. Had your medical or psychiatric fitness for a job or educational studies questioned by a supervisor or a supervising institution?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever left school or any position because of ill health?	<input type="checkbox"/>	<input type="checkbox"/>
10. Lost time from work or school in the past three years for medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>

Provide *full details* here for all questions answered “Yes.” *Full details* include the condition, dates and durations. List the question number when answering. Use additional sheets if necessary.

## Outline for Physical Examination

1. (a) How long have you known applicant \_\_\_\_\_ (b) in what relationship? \_\_\_\_\_
2. (a) height without shoes: \_\_\_\_\_ (b) weight: \_\_\_\_\_

### Vital Signs

Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_ Blood Pressure \_\_\_\_\_  
(arm, R or L position)

**Physical Examination: Check for within normal limits. Note positive findings in the space below.**

### Head

- Eyes: vision   
 conjunctivae and sclerae   
 pupils size   
 reaction   
 equality   
 appearance   
Ears: hearing   
 air and bone conduction   
 appearance of tympanic membranes   
Nose: obstruction to breathing   
 septal deviation and/or perforation   
 discharge   
Mouth: sores   
 dental status   
 appearance and palpation of mucosa, tongue, gums, floor of mouth   
 appearance of tonsils, pharynx   
 appearance & movement of uvula, palate   
 gag reflex

### Lymph Nodes

- Enlargement, consistency and/or tenderness of cervical, axillary, epitrochlear, popliteal, and inguinal glands

### Chest

- Appearance and function of chest wall   
Breasts: appearance, asymmetry, tenderness, masses, nipple discharge   
Lungs: type of respiration, character of breath sounds; presence of rales, rhonchi, wheezes or rubs

### Heart

- Apex location, precordial movements or thrills   
Auscultation:  
 heart sounds: S1, S2, S3, S4   
 presence of murmurs, clicks, rub, split sounds   
 radiation of murmurs

### Neck

- Palpable masses   
 Thyroid   
 Location of trachea   
 Venous engorgement   
 Bruits   
 Flexibility

### Pulses

- Carotids   
 Brachials   
 Radials   
 Femorals   
 Dorsalis pedis   
 Posterior Tibials

### Summary of positive findings:

**Outline for Physical Examination**

(con't from previous page)

**Spine**

- Mobility
- Tenderness
- Curvature

**Abdomen**

- Appearance (distended, flat, scaphoid)
- Abnormal movements
- Dilated veins
- Striae
- Auscultation:
  - bowel sounds
  - bruits
  - rubs
- Percussion:
  - distention
  - organ size (liver, spleen, bladder)
- Palpation:
  - resistance
  - tenderness
  - rebound
  - organs (liver, spleen, bladder)
  - masses
  - epigastric or incisional hernia

**Neurological**

- Mental status
- Cranial nerves
- Cerebellar function
- Muscle strength
- Reflexes
- Gait and station
- Rapid Sensory exam including vibratory

**Extremities**

- Skin color
- Temperature
- Texture
- Varicosities
- Clubbing
- Edema
- Joint Motions
- Muscular Abnormalities
- Circumference

**Genital, Prostate or Pelvic Examination**

List any abnormal findings:

**Rectal Exam and Stool Sample**

List positive findings:

**LABORATORY**

- CBC \_\_\_\_\_
- Fasting Chem Profile \_\_\_\_\_
- U/A \_\_\_\_\_
- EKG (if indicated) \_\_\_\_\_
- PPD \_\_\_\_\_

On the basis of your examination, is the candidate free from any medical condition or other impediment that would render him/her unsuitable for the tasks of ordained ministry? (If you have any confidential information that would render the candidate unacceptable, please so indicate here and forward details to the Bishop by confidential communication.)

This report should be mailed by examiner directly to the Bishop, and the information should be treated as strictly confidential.

\_\_\_\_\_  
Examiner's Signature M.D.

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number/Fax Number

Check the appropriate box for the disorders you have or have had in the past.

	Yes	No		Yes	No
<b>Infectious Diseases</b>			<b>Respiratory System</b>		
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Dysentery (Chronic)	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Infantile Paralysis (Polio)	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Skin diseases or eczema	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Chronic hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Chills	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Lymph node enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
<b>Heart and Blood Vessels</b>			<b>Nervous System</b>		
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epileptic or other fits	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Pain in chest	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Mental or nervous diseases (family)	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mental or nervous diseases (self)	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	Visual problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Coagulation disorder	<input type="checkbox"/>	<input type="checkbox"/>	Ringing ears, hearing difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Weakness of limbs	<input type="checkbox"/>	<input type="checkbox"/>
<b>Digestive System</b>			<b>Miscellaneous</b>		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma or Other Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or sugar disease (family)	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or sugar disease (self)	<input type="checkbox"/>	<input type="checkbox"/>
Bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Marked over or underweight	<input type="checkbox"/>	<input type="checkbox"/>	Foot problems	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to any food, medicine or injection	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
<b>Genitourinary System</b>			Arthritis		
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Use of nicotine on daily basis in the past five years.		
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been a habitual user of any habit forming drugs or received treatment for alcoholism or drug abuse?		
Prostate disease	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any illnesses (mental or physical) or accidents other than those mentioned?		
Bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in passing urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I hereby declare that my answers to the above questions are full and true.

Signed at \_\_\_\_\_ in my presence,  
this \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_.

(Full signature of applicant)

(Physician)