CONFIDENTIAL HEALTH FORM

for

_____

STUDENT NAME

Physician: Please return completed form to:

Diocese of Portland
Director of Seminarians
510 Ocean Avenue
Portland, Maine 04103-4936

This information is strictly for the use of the Diocese of Portland, ME and will not be released to anyone without your knowledge or consent.

REPORT OF MEDICAL HISTORY

PLEASE COMPLETE THIS PAGE BEFORE GOING TO THE PHYSICIAN FOR EXAMINATION

LAST NAME (Print) | FIRST NAME | MIDDLE | DATE OF BIRTH | HOME TELEPHONE

HOME ADDRESS (Number and Street) | CITY OR TOWN | STATE | ZIP CODE

FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives ever had any of the following?	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			
Alcoholism			

PERSONAL HISTORY

PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below or on additional sheet.

HAVE YOU HAD?	Yes	No
Scarlet Fever		
Measles		
German Measles		
Mumps		
Chicken Pox		
Malaria		
Gum or Tooth Trouble		
Sinusitis		
Eye Trouble		
Ear, Nose, Throat Trouble		
Surgery		
Appendectomy		
Tonsillectomy		
Hernia Repair		
Other		

	Yes	No
Insomnia		
Frequent Depression		
Worry or Nervousness		
Recurrent Headache		
Head Injury with Unconsciousness		
Hay Fever, Asthma		
Tuberculosis		
Allergy		
Penicillin		
Sulfonamides		
Serum		
Foods (which)		
Other		
Pain/Pressure in Chest		

	Yes	No
Palpitations (Heart)		
High or Low Blood Pressure		
Rheumatic Fever or Heart Murmur		
Disease or Injury of Joints		
"Trick" Knee, Shoulder, etc.		
Back Problems		
Tumor, Cancer, Cyst		
Jaundice		
Stomach or Intestinal Trouble		
Gallbladder Trouble or Gallstones		
Rupture, Hernia		
Recent Gain or Loss of Weight		

	Yes	No
Dizziness, Fainting		
Weakness, Paralysis		
Venereal Disease		
Albumin/Sugar in Urine		
Frequent Urination		
Shortness of Breath		
Recurrent Colds		
Chronic Cough		
Recurrent Diarrhea		
Night Sweats		
Swelling of Glands		
Skin Rash		
Other		

	Yes	No
A. Has your physical activity been restricted during the past five years? (Give reasons and durations)		
B. Have you had difficulty with school, studies, or teachers? (Give details)		
C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (Give details)		
D. Have you had any illness or injury or been hospitalized other than already noted?		
E. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine check ups?)		
F. Have you been rejected for or discharged from military service because of physical, emotional, or other reasons? (If so, give reasons)		
G. Do you have any question in regard to your health, family history, or other matters which you would like to discuss?		
H. Have you ever used intravenous or injectible drugs?		
I. Have you had sexual contact with another male or with a prostitute in the past seven years?		

Remarks or Additional Information
(Use back page if necessary)

I hereby certify that the above information is true and complete. Date
Student's Signature

Physician's Signature (Acknowledging Review) Date

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: **Please review the student's history and complete the physician's form. Please comment on all positive answers. This information is strictly for the use of the Diocesan/Seminary Admissions Boards and will not be released without student consent.**

LAST NAME FIRST NAME MIDDLE

BP

Height _____inches Weight _____lbs.

Corrected Vision

Overwight _____ Underweight _____

Right 20/ Left 20/

Tuberculin Skin Test: Positive _____ Negative _____

URINALYSIS

Sugar_____

Albumin_____

Micro._____

HIV_____

VDRL_____

HEPB SER._____

IMMUNIZATION

	Completed		
	Yes	No	Date of Last Injection
Required			
Tetanus within 10 yrs			
Recommended			
Polio			
Diptheria			

Are there abnormalities of the following systems? Describe fully. Use back page if necessary.

	Yes	No
1. Head, Ears, Nose, Throat		
2. Respiratory		
3. Cardiovascular		
4. Gastrointestinal		
5. Hernia		
6. Eyes		
7. Genitourinary		
8. Musculoskeletal		
9. Metabolic/Endocrine		
10. Neuropsychiatric		
11. Skin		

Is there loss or seriously impaired function of any paired organ? _____Yes _____No

Have you any general comments?

Recommendations for physical activity (PE, Intramurals) Unlimited_____ Limited_____ Explain:

Do you have any recommendations regarding the care of this student? Yes_____ No_____

Is the patient now under treatment for any medical or emotional condition? Yes_____ No_____

PHYSICIAN'S SIGNATURE_____

ADDRESS_____

PRINT LAST NAME_____ DATE_____

ADDITIONAL REMARKS OR COMMENTS