Required Medical Examination

This report should be mailed by the examiner directly to the Bishop at the address below, and the information should be treated as strictly confidential. By submitting to the examination, the candidate consents to the use of the information herein in The connection with candidacy to the Office of Deaconess.

The Episcopal Diocese for Fort Worth, 2900 Alemeda Street, Fort Worth, Texas 76108

Medical History and Physical Form

Name	Date of Birth
Home Address	Phone Number
Marital Status	Children and Ages
Notify in Case of Illness or Emergency	Phone Number
Personal Physician	Phone Number and Address

Medical History and Review of Systems

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

Infectious Disease	Yes	No	**Respiratory Disease**	Yes	No
Pneumonia			Sinus Infection		
Frequent Sore Throats			Asthma		
Dysentery (Chronic)			Hay fever		
Infantile Paralysis (polio)			Bronchitis		
Syphilis			Pleurisy		
Gonorrhea			Tuberculosis		
Skin Diseases or Eczema			Chronic Cough		
Fevers			Chronic Hoarseness		
Recurrent Chills			Coughing Up Blood		

Lymph Node Enlargement			Tobacco Use or Vaping		
Heart and Blood Vessels	Yes	No	**Nervous System**		
High or Low Blood Pressure			Epileptic or Other Seizure		
Heart Disease			Meningitis		
Pain In Chest			Mental or Nervous Disease (Self)		
Rheumatic Fever			Mental or Nervous Disease (Family)		
Heart murmur			Dizzy Spells		
Palpitations			Fainting Spells		
Shortness Of Breath			Visual Problems		
Swollen ankles			Deafness		
Anemia or Blood Disease			Ringing ears or hearing difficulty		
Coagulation disorder			Paralysis		
Elevated Cholesterol			Weakness of limbs		
			Numbness or Tingling Sensation		
Digestive System	Yes	No	**Miscellaneous**	Yes	No
Ulcers			Cancer		
Jaundice			Lymphoma or Other Blood Disease		
Hepatitis			Diabetes or Hypoglycemia (Self)		
Recurrent Diarrhea			Diabetes or Hypoglycemia (Family)		
Bloody Stools or Rectal Bleeding			Thyroid disease		
Marked Over or Under Weight			Foot problems		
Recent Weight Loss			Back Pain		
Gall Bladder disease			Joint pain		
Hernia			Allergy to Any Food, Medicine, or Injection		
Genitourinary System	Yes	No	Blood transfusions		
Kidney Disease			Arthritis		
Kidney Stones			Daily Use of Tobacco (past 5 years)		
Blood In Urine			Use of Any Habit-Forming Drug		

Pain In Passing Urine			Received Treatment For Alcoholism or Drug Abuse		
Recurrent Urinary Tract Infections			Any Illnesses (Mental or Physical) or Accidents Other Than Those Mentioned Above?		

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

_____

(Full signature of applicant)

Signed in my presence on _ _/_ _/20_ _

_____

(Signature of Physician, Physician Associate or Nurse Practitioner)

Physical Examination (to be done by Physician, Physician Associate or Nurse Practitioner}

As a healthcare provider, how long have you known the applicant?
Did you review the applicant's medical history and review of systems form?

Vital Signs

Height ft in	Weight lbs
Temperature °F	Pulse
Respiration	Blood Pressure From which arm? Left or Right
Vision Left /20 Right /20	Vision with correction? Yes or No

Place check mark for normal or abnormal findings. Note positive (abnormal) findings in the comment section.

Category	Nl	Abnl	Describe any abnormal findings
General Appearance			
HEENT			
Neck			
Chest and Lungs			

Category	Nl	Abnl	Describe abnormal findings, if any
Cardiovascular			
Abdomen			
Spine			
Extremities			
Lymph Nodes			
Skin			
Neurologic			

Tuberculosis Screening: Skin or Blood Test

Mantoux Date given _ _/_ _/20_ _ Date Read _ _/_ _/20_ _

_____mm Interpretation ( ) Negative ( ) Positive

Blood Test (Quantiferon-TB Gold Results) ( ) Negative ( ) Positive

_____ Date _____/_____/ 20__

(Signature of Physician, Physician Associate, or Nurse Practitioner and Date)