PRIESTLY FRATERNITY OF ST. PETER

MEDICAL RECORD FORM

Date_____

Name_____ Date of Birth_____

First MI Last .

Address_____

City/State/Zip/Country_____

Home phone # (_____)_____ Work phone # (_____)_____

Emergency Contact (Name)_____ Relationship_____

Home phone # (_____)_____ Work phone # (_____)_____

MEDICAL HISTORY

Do you or have you ever had:

Scarlet Fever		Neck Pain		Arm or Leg Numbness	
Chicken Pox		Neck Stiffness		Arm or Leg Weakness	
Mononucleosis		Neck Lumps		Tingling Sensation	
Sexually Transmitted Disease		Shortness of Breath		Seizures	
HIV/AIDS		Unexplained Coughing		Dizziness	
Tuberculosis		Asthma		Fainting	
Allergies to Food		Hypertension		Unexplained Falling	
Allergies to Drugs		Unexplained Chest Pains		Joint Pain	
Allergies to Pollens		Heart Pounding or Racing		Joint Stiffness	
Allergies to Animals		Heart Murmur		Joint Swelling	
Fatigue or Generalized Weakness		Unexplained Swelling		Muscle Pain	
Recurrent Fevers		Blood Clots		Muscle Weakness	
Recurrent Chills		Abdominal Pain		Nervousness	
Unexplained Sweating		Recurrent Heartburn		Sleeping Difficulties	
Unexplained Weight Loss		Swallowing Difficulties		Recurrent Headaches	
Unexplained Weight Gain		Nausea		Rashes	
Vision Changes		Recurrent Vomiting		Tumors	
Loss of Vision		Recurrent Diarrhea		Skin Cysts	
Hearing Changes		Recurrent Constipation		Cancer	
Loss of Hearing		Bloody Stools		Anemia	
Recurrent Ear Infections		Kidney Stones		Transfusions	
Recurrent Sinus Infections		Kidney or Bladder Infections		Diabetes	
Recurrent Nose Bleeds		Urinary Frequency		Hypoglycemia	
Dyspraxia/DCD		Pain or Burning with Urination		Gluten Intolerance	
Depression		Mood Disorder		Crohn's Disease or Colitis	
ADHD/ADD (*Attention Deficit Hyperactivity Disorder*)		Asperger's		High Cholesterol	

FAMILY HISTORY

Fill in the following chart to the best of your knowledge. Place a check mark (✓) in the box below if one family member has had the condition, give the number who had the condition if more than one. If you don't know if the condition existed in a family member/s put a question mark (?) in the box.

	Father	Mother	Paternal Grandparents	Maternal Grandparents	Father's Siblings	Mother's Siblings	Your own Siblings
Asthma							
Cancer (note type of cancer if you know that information)							
Depression							
Diabetes							
Epilepsy							
Gluten intolerance							
Heart Disease							
Hypertension							
Neurologic Disease							
Pshychiatric Disease							
Stroke							

SOCIAL HISTORY

	Yes/No	Quantity Per Day		Yes/No	Quantity Per Day
Tobacco			Alcohol		

HOSPITALIZATIONS

Hospitalizations/Operations	Date

MEDICATIONS

Medication	Date

Please clarify any of the medical history (if necessary): _____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature Date

_____ _____

Signature of Parent or Guardian* Date

**If the applicant is under eighteen years of age, this form must also be signed by a parent or guardian*

PHYSICAL EXAMINATION

This section is to be completed by physician

Blood Pressure _____/_____ Pulse _____ Resp._____ Temp. _____ Height ____ft _____in Weight _____lbs

	Normal	*Abnormal*	*Findings*
General			
Head			
Eyes			
Acuity			OU / OS / OD /
Color Vision			
Ears			
Hearing			
Nose			
Mouth			
Neck			
Thorax			
Lungs			
Heart			
Pulses			
Abdomen			
Genitourinary			
Hernia			
Rectal			
Back/Spine			
Muscular-Skeletal			
Neurologic			
Dermatologic			

LABORATORY (please attach lab reports)

	Normal	*Abnormal*	*Findings*
Thyroid Panel			
Urinalysis			
Blood Sugar			
HIV			
Drug			

Recommendations for physical activity (sports, etc.): Unlimited _____ Limited _____

Limitations _____

_____

_____

_____

Recommendations regarding care of this applicant _____

_____

_____

_____

Physician Name _____ Phone (_____)_____

Address_____

City/State/Zip/Country_____

Physician Signature_____ Date _____