THE UNITED METHODIST CHURCH MEDICAL REPORT OF MINISTERIAL CANDIDATE

NOTE: THIS FORM IS NOT IN A FILLABLE FORMAT. MUST BE PRINTED OFF AND TURNED IN.

Candidate's Last Name: _____
First:_____ Middle: _____
Date of Birth (mm/dd/yyyy): _____

To the Board of Ordained Ministry:
Please indicate here, the name/address of the board officer who will receive this report.

Name: _____

Address: _____

_____

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION – COMPLETED BY CANDIDATE

Candidate Name:_____ Date of Birth: _____

I hereby authorize and direct (physician)_____, to disclose to the (annual conference)_____ Board of Ordained Ministry the following information with regard to the records of (candidate) _____ for the purpose of evaluation by The United Methodist Church for entrance into ministry.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This consent will expire sixty (60) days after the date treatment is terminated unless another date is specified.

I understand that the information requested may be disclosed from records whose confidentiality is otherwise protected by federal as well as state law. Any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis and treatment of psychological disorders, as well as HIV status.

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

_____ _____
Signature of candidate Date

_____ _____
Witness Date

Candidate's Last Name:	
First:	Middle:
Date of Birth (mm/dd/yyyy):	

Please note: The candidate's physician should make the final determination regarding the need for specific medical tests as related to the overall health and needs of the candidate.

Part I: Personal History Report **To be completed by the candidate.**

Medical problems experienced at any time by YOU or a first degree family member (mother, father, sister, brother, son or daughter):

PROBLEMS	YOU	Any close family member
Diabetes	NO / YES	NO / YES
Hypertension	NO / YES	NO / YES
High cholesterol	NO / YES	NO / YES
Heart problems (specify)	NO / YES	NO / YES
Asthma or emphysema	NO / YES	NO / YES
Cancer (specify type)	NO / YES	NO / YES
Anemia/excess bleeding/blood clots	NO / YES	NO / YES
Arthritis/back pain	NO / YES	NO / YES
Stomach/bowel problems	NO / YES	NO / YES
Kidney/bladder problems	NO / YES	NO / YES
Depression/ Anxiety	NO / YES	NO / YES
Sleep apnea	NO / YES	NO / YES
Stroke	NO / YES	NO / YES
Sexually transmitted disease	NO / YES	
Other		

Surgeries in your lifetime: _____

_____

_____

_____

_____

Social History (list any **past or present use** of substances):

Cigarettes	NO / YES Packs per day #:	Years smoking #:
Cigars	NO / YES	
Smokeless tobacco	NO / YES	
Alcohol	NO / YES Drinks per week (beers/wine/liquor) #:	
Recreational drugs	NO / YES Substance used:	
IV drug use	NO / YES Date:	Results of last HIV test:

Candidate's Last Name:	
First:	Middle:
Date of Birth (mm/dd/yyyy):	

Part I, continued…

Health Behaviors:

How often do you exercise 30 minutes in a day?

_____almost never
_____1-4 days/ week
_____5 or more days/ week

How often do you intentionally limit complex carbs/starches/sweets and fats in your diet?

_____never
_____sometimes
_____always

Have you ever been the victim of physical, emotional or sexual abuse in your lifetime?

NO / YES _____

If so, do you live/work in a safe environment now? _____

Vaccination History:

VACCINE (TIMING/AGE)	DATE OR YEAR ADMINISTERED
Influenza (yearly)	
Tetanus/diphtheria/pertussis (TDAP) (every 10 years)	
Pneumonia vaccine (once over 65 years old)	
HPV series (women 9-26 years old)	
Shingles vaccine (once over 50 years old)	
Others	

Tuberculosis Exposure History:

Visitation/ mission work in hospitals, prisons, homeless shelters, nursing homes, underdeveloped countries or exposure to anyone with known TB infection?	NO / YES If yes, when was your last TB screening test? Date: Results:

Candidate's Last Name:	
First:	Middle:
Date of Birth (mm/dd/yyyy):	

Part II: Physical Exam **To be completed by examining provider.**

BIOMETRIC	RESULT	NORMAL RANGES
Weight	lbs.	
Height	inches	
Waist measurement	inches	(Men < 40 inches, women <35 inches)
BMI		<25 normal, 25-30 overweight, 30-40 obese, >40 extreme obesity
Blood pressure		<120/80
Pulse		60-100

SYSTEM	NORMAL / ABNORMAL (SPECIFY) / NA
HEENT	
Chest/lungs	
Heart/vascular	
Abdomen	
GU (prostate or pelvic exam if appropriate)	
Skin	
Joints/Spine	
Lymphatics	
Neurological	
Mood	

Labs/imaging:

SCREENING TEST (age)	RESULT	DATE
Fasting glucose		
Fasting Total cholesterol		
LDL		
HDL		
Triglycerides		
Last PAP smear (20-65)		
Last Mammogram (>40)		
Last PSA (men 50-70 if desired)		
Last Colonoscopy (>50)		
Bone density (females >65)		
AAA screening (male smokers >65)		

Candidate's Last Name:	
First:	Middle:
Date of Birth (mm/dd/yyyy):	

Part II, continued…

Health Assessment: _____

_____

_____

_____

_____

Plan/Recommendations to candidate: _____

_____

_____

_____

_____

Physician recommendations to the Board of Ordained Ministry related to candidate: _____

_____

_____

_____

_____

_____

Examining Provider: _____

Address: _____

_____

Phone: _____

Fax: _____

Signature: _____ Date: _____

STAMP

Medical Form Background Information

Candidate's Last Name:
First: Middle:
Date of Birth (mm/dd/yyyy):

The following lists show standard screening practices on which this document is based. Additionally, the physician may choose to make recommendations to the candidate as needed based on the Key Points listed below.

Key screening advice taken from large consensus groups like US preventative task force and evidence-based information:

Screening

Height and weight (periodically)
Blood pressure
Alcohol and tobacco use
Depression (if appropriate follow-up is available) Diabetes
mellitus (patients with hypertension)
Dyslipidemia (total and HDL cholesterol): men ≥35 y; men or women ≥20 y who have cardiovascular risk factors; measure every 5 y if normal
Colorectal cancer screening (men and women 50-75 y)
Mammogram every 1 to 2 y for all women ≥40 y. Evaluation for BRCA testing in high-risk women only.
Papanicolaou test (at least every 3 y until age 65 y)
Chlamydial infection (sexually active women ≤25 y and older at-risk women) Routine
voluntary HIV screening (ages 13-64 y)
Bone mineral density test (women ≥65 y and at-risk women 60-64 y) AAA
screening (one time in men 65-75 y who have ever smoked)

Counseling—Substance Abuse

Tobacco cessation counseling
Alcohol misuse: brief office behavioral counseling; alcohol abuse: referral for specialty treatment

Counseling—Diet and Exercise

Behavioral dietary counseling in patients with hyperlipidemia, risks for CHD and other diet-related chronic disease
Regular physical activity (at least 30 minutes per day most days of the week) Intensive counseling/behavioral interventions for obese patients

AAA = abdominal aortic aneurysm; BRCA = breast cancer susceptibility gene; CHD = coronary heart disease.

Based on recommendations from the U.S. Preventive Services Task Force.

Candidate's Last Name:	
First:	Middle:
Date of Birth (mm/dd/yyyy):	

Key Points

- The U.S. Preventive Services Task Force recommends routine periodic screening for hypertension, obesity, dyslipidemia (men ≥35 years), osteoporosis (women ≥65 years), abdominal aortic aneurysm (one-time-screening), depression, and HIV infection.
- The U.S. Preventive Services Task Force recommends routine periodic screening for colorectal cancer (persons 50-74 years of age), breast cancer (women ≥40 years), and cervical cancer.
- The U.S. Preventive Services Task Force recommends that all pregnant women be screened for asymptomatic bacteriuria, iron-deficiency anemia, hepatitis B virus, and syphilis.
- The U.S. Preventive Services Task Force recommends against screening for hemochromatosis; carotid artery stenosis; coronary artery disease; herpes simplex virus; or testicular, ovarian, pancreatic, or bladder cancer.
- Outside of prenatal, preconception, and newborn care, genetic testing should not be performed in unselected populations because of lower clinical validity; potential for false positives; and potential for harm, including "genetic labeling."
- For patients for whom genetic testing may be appropriate, referral for genetic counseling should be provided before and after testing.
- A human papillomavirus vaccine series is indicated in females ages 9 through 26 years, regardless of sexual activity, for prevention of cervical cancer.
- A single dose of tetanus-diphtheria–acellular pertussis (Tdap) vaccine should be given to adults ages 19 through 64 years to replace the next tetanus-diphtheria toxoid (Td) booster.
- A zoster (shingles) vaccine is given to all patients 60 years and older regardless of history of prior shingles or varicella infection.
- Asymptomatic adults who plan to be physically active at the recommended levels do not need to consult with a physician prior to beginning exercise unless they have a specific medical question.
- Smoking status should be determined for all patients.
- Patients who want to quit smoking should be offered pharmacologic therapy in addition to counseling, including telephone quit lines.
- Routine screening is recommended to identify persons whose alcohol use puts them at risk.
- For management of alcohol abuse and dependence, referral for specialty treatment is recommended; for management of alcohol misuse, brief behavioral counseling may be useful.
- Clues for chemical dependency include unexpected behavioral changes, acute intoxication, frequent job changes, unexplained financial problems, family history of substance abuse, frequent problems with law enforcement agencies, having a partner with substance abuse, and medical sequelae of drug abuse.
- Condom use reduces transmission of HIV, Chlamydia, gonorrhea, Trichomonas, herpes virus, and human papillomavirus.

- It is important to ask about domestic violence when patients present with symptoms or behaviors that may be associated with abuse.
- When an abusive situation is identified, address immediate safety needs.