Medical Examination Form for the Ordination Process

Applicant Name: _____ Date of Exam: _____

This section, health history, is completed by the Aspirant. Provide full details for all "yes" answers. Attach additional sheets if necessary, listing the question number with the response.

1. Please list any active or chronic medical conditions for which you are currently under a physician's care such as high blood pressure, diabetes, heart disease, asthma, epilepsy or cancer?

   _____

2. Please list any past surgeries.

   _____

3. Please list any hospitalizations in the past 10 years both date and reason for admission:

   _____

4. Please list all medication, food, insect/ animal or other allergies:

   _____

5. Please list any prescription medications, over the counter, herbal, or vitamins you currently take or have taken in the past year, including the dosage, frequency of dose, and how long you have been on it:

   _____

6. Do you have a physical disability or a learning disability that affects your ability to read or write?
7. □ YES □ NO

8. Are you presently seeing a counselor or other medical professional for emotional or psychological support? □ YES □ NO

9. Have you ever received treatment for a psychiatric condition (depression, anxiety, bipolar disorder, eating disorders, etc.)? □ YES □ NO

10. Do you smoke? □ YES □ NO

11. Have you ever received treatment for alcohol, drug or other substance use? □ YES □ NO

12. Have you received Workmen's Compensation or other disability benefits? □ YES □ NO

13. Have you ever been rejected for employment on account of any physical or mental condition? □ YES □ NO

14. Have you ever lost time from work or school in the past three years for medical reasons? □ YES □ NO

15. Is there any additional information that would be helpful for us to be aware of? □ YES □ NO If YES, please describe:

    _____

This Section to be completed by Health Care Provider (MD, DO, CRNP, PA):

How long have you known the applicant and in what capacity?

_____

Physical Examination:

Age: _____ Gender: ☐ M ☐ F

Height: _____ Weight: _____ BP: _____ BMI: _____

General appearance: _____

HEENT: _____

Lungs: _____

CV: _____

ABD: _____

Ext: _____

Skin: _____

Neuro: _____

Recommendations:

_____

Signature of Medical Provider & Date *Print Name & Credential of Medical Provider*

Medical Office Address and Phone Number: _____

Upon completion, please mail to: Anglican Diocese of Pittsburgh
Office of the Bishop
907 Middle Street
Pittsburgh, PA 15212