Region XII Common Seminary Application

MEDICAL HISTORY OF APPLICANT FOR THE SEMINARY

Applicant: Please fill in this form by typing in the spaces provided, and present it to your physician prior to the examination.

1. APPLICANT NAME

Last Name	*First Name*	*Middle Name*
Birthdate (mm/dd/yyyy)	*City, State of Birth*	*Biological Sex*

2. REQUIRED DOCUMENTATION

Please request and submit the following documentation with this form:

- ○ Your medical and dental insurance cards
- ○ A copy of your vaccination records

3. FAMILY HISTORY

Has a family member ever had:	No	Yes	Who in your family had this?
Allergies	◎	◎	
High Cholesterol	◎	○	
Asthma	◎	○	
Kidney Disease	◎	○	
Cancer (which type?)	◎	○	
Mental Illness	◎	○	
Diabetes (which type?)	○	◎	
Nervous Disorder	○	○	
Heart Disease	○	○	
High Blood Pressure	○	◎	

4. GENERAL MEDICAL HEALTH AND LIFESTYLE

4.1 Describe your current physical and mental health (20 words or fewer):

4.2 Do you smoke? ○ **No** ◎ **Yes**

If yes, what do you smoke?

☐ E-Cigarettes ☐ Cigars ☐ Cigarettes ☐ Pipe

If yes, how often or how much (e.g., times/week, packs/day, mg of nicotine/day)?

4.3 Do you use chewing tobacco or snuff? ○ No ○ Yes

If yes, how often or how much (e.g., times/week, mg of nicotine/day)?

4.4 Do you drink alcohol? ○ No ○ Yes

If yes, how often or how much (e.g., number of drinks/week)?

4.5 Do you exercise? ○ No ○ Yes

If yes, how often do you exercise?

☐ Daily ☐ 2-3 times/week ☐ Occasionally ☐ Never

If yes, what type of exercise do you do (20 words or fewer)?

4.6 Did you miss any days of school or work in the last 12 months due to illness? ○ No ○ Yes

If yes, how many days did you miss? _____

If yes, what was the cause?

4.7 Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? ○ No ○ Yes

4.8 Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years other than routine checkups? ○ No ○ Yes

4.9 Have you ever used any illegal drugs or substances, or misused prescription drugs? ○ No ○ Yes

4.10 Have you ever used any marijuana? ○ No ○ Yes

4.13 Have you had sexual contact with anyone within the past two years outside of marriage? ○ No ○ Yes

4.14 Have you been denied life insurance, rejected by or discharged from military service, or refused employment because of your health? ○ No ○ Yes

4.15 Have you ever been unable to take physical education or participate in sports because of your health? ○ No ○ Yes

4.16 When is the last time you visited your dentist? _____

4.17 When is the last time you visited your eye doctor? _____

If you answered "Yes" to any of the questions above, please explain, using a separate sheet if necessary:

5. PERSONAL MEDICAL HISTORY

5.1 Please list any serious illnesses or hospitalizations you have had (70 words or fewer):

5.2 Please list any previous surgeries or injuries (e.g., broken bone, head injury) you have had (70 words or fewer):

5.3 Pease list all prescription and OTC medications you are currently taking, including supplements (70 words or fewer):

5.4 Please indicate the presence, description, and severity of any allergies you have:

	No	Yes	Description	Life-Threatening
Drugs	◯	◯		☐
Foods	◯	◯		☐
Plants	◯	◯		☐
Insects	◯	◯		☐
Other	◯	◯		☐

Please check any of the following conditions you have had:

Have you ever had:	No	Yes	Have you ever had:	No	Yes
ADHD	◯	◯	Heart Murmur	◯	◯
Anxiety /Depression	◯	◯	Irregular Heartbeat	◯	◯
Arthritis	◯	◯	Heart Palpitations	◯	◯
Celiac Disease	◯	◯	Chest Pain	◯	◯
Concussion	◯	◯	Elevated Cholesterol	◯	◯
Recurrent Headaches/Migraines	◯	◯	Marfan's Syndrome	◯	◯
Head injury with unconsciousness	◯	◯	Shortness of Breath ☐ with ☐ without exercise (*specify*)	◯	◯
Asthma	◯	◯	Rheumatic Heart Disease	◯	◯
Pneumonia	◯	◯	Pacemaker	◯	◯
Tuberculosis (or exposure)	◯	◯	☐ High ☐ Low Blood Pressure (*specify*)	◯	◯
HIV	◯	◯	Seizures (epilepsy)	◯	◯
Diabetes	◯	◯	Bleeding Disorder	◯	◯
Cancer (including Hodgkins or Leukemia)	◯	◯	Ever dizzy, pass out, or faint during exercises?	◯	◯
Sickle Cell Trait	◯	◯	Thyroid Problems	◯	◯

Have you ever had:	No	Yes
Intestinal Problems	◯	◯
Colitis	◯	◯
Stomach Ulcers	◯	◯
Hemorrhoids/Rectal Bleeding	◯	◯
Anemia	◯	◯
Hepatitis (*specify*) ☐ A ☐ B ☐ C	◯	◯
Hernia	◯	◯
Cystic Fibrosis	◯	◯
Hearing Loss (*specify*) ☐ Total ☐ Partial	◯	◯
Blindness (*specify*) ☐ Total ☐ Partial	◯	◯
Mitral Valve Prolapse	◯	◯

Have you ever had:	No	Yes
Kidney Problems	◯	◯
Orthopedic Injury	◯	◯
Bipolar disorder	◯	◯
Emotional Disorder	◯	◯
Eating Disorder	◯	◯
Breast changes	◯	◯
Suicide Attempt	◯	◯
Scrotal lump	◯	◯
Testicular lump	◯	◯
Gender Dysphoria	◯	◯
Sleep Apnea	◯	◯

5.5 Do you have any question in regard to your health, family history, or other matters which you would like to discuss with a health professional? ◯ **No** ◯ **Yes**

If yes, please explain:

6. APPLICANT ATTESTATION

I verify that the information provided on this form is complete and accurate to the best of my knowledge.

Signature of Applicant *Date*