

Applicant's Name

**Diocese of San Bernardino**

# **CONFIDENTIAL HEALTH FORM**



## **NOTICE TO EXAMINING PHYSICIAN**

The above-named individual is applying for admission to a program of priestly formation in the Roman Catholic Church. Part of the application process includes a thorough physical examination. Church law requires that applicants must have a good health which will enable them to undergo the rigors of the seminary as well as the life-long obligations of the priesthood. We rely on your professional expertise to assist us to determine that this applicant is in good health. Thank you.

**PHYSICIAN: Please return completed form to:**

**VOCATIONS OFFICE  
12716 Oriole Ave.  
Grand Terrace, CA 92313  
(909) 783-1305**

**NOTE:** This information is strictly for the use of the Diocese of San Bernardino and will not be released to anyone else without the knowledge or consent of the applicant.

## APPLICANT'S REPORT OF MEDICAL HISTORY<sup>1</sup>

LAST NAME (Print)	FIRST NAME	MIDDLE	DATE OF BIRTH	TELEPHONE NO.
HOME ADDRESS (Number and Street)		CITY	STATE	ZIP CODE
NAME OF HEALTH INSURANCE (If any)		GROUP NO.	MEMBER NO.	

### PERSONAL AND FAMILY HISTORY

PLEASE ANSWER ALL QUESTIONS. Explain all positive answers in the space provided.

HAVE ANY OF YOUR RELATIVES EVER HAD ANY OF THE FOLLOWING?				EXPLANATIONS:
	YES	NO	Relationship	
Tuberculosis				
Diabetes				
Kidney Disease				
Heart Disease				
Arthritis				
Stomach Disease				
Asthma, Hay Fever				
Epilepsy, Convulsions				
Alcoholism, Drug Addiction				

HAVE YOU EVER HAD OR NOW HAVE ANY OF THE FOLLOWING?						EXPLANATIONS:
	YES	NO		YES	NO	
Scarlet Fever			Palpitations (Heart)			
Measles			High/Low Blood Pressure			
German Measles			Rheumatic Fever			
Mumps			Heart Murmur			
Chicken Pox			Disease/Injury of Joints			
Malaria			«Trick» Knee, Shoulders, etc.			
Gum/Tooth Trouble			Back Problems			
Sinusitis			Tumor, Cancer, Cyst			
Eye Trouble			Jaundice			
Ear, Nose, Throat Problems			Stomach/Intestinal Problems			
Surgery			Gallbladder Trouble			
Appendectomy			Rupture, Hernia			
Tonsillectomy			Recent Weight Gain/Loss			
Hernia Repair			Dizziness, Fainting			
Other			Weakness, Paralysis			
Insomnia			Venereal Disease			
Frequent Depression			Albumin/Sugar in Urine			
Excessive Nervousness			Frequent Urination			
Recurrent Headaches			Shortness of Breath			
Unconsciousness			Recurrent Diarrhea			
Asthma, Hay Fever			Recurrent Colds			
Tuberculosis			Chronic Coughs			
Allergies			Night Sweats			
Penicillin			Swelling of Glands			
Sulfonamides			Skin Rash			
Serum			Chest Pains/Pressure			
Foods (which?)			Drug Addiction			
Other (specify)			Alcoholism			
Epilepsy			Other (specify)			

<sup>1</sup> APPLICANT: Please complete this page before going to the physician for examination

PLEASE EXPLAIN OR CLARIFY ALL POSITIVE ANSWERS	EXPLANATIONS:	
	YES	NO
Has your physical activity been restricted during the past five years?		
Have you received treatment or counseling for any nervous condition, personality or character disorders, or emotional problems?		
Have you been hospitalized for any illness or injury not already mentioned above?		
Have you been or are you now under a physician's care for an extended period of time?		
Have you ever used intravenous or injectible drugs?		
Are you currently on any form of medication?		
Have you been rejected for or discharged from military service because of physical, emotional, or other reasons?		
Do you have any questions in regard to your health, family history, or other matters which you would like to discuss?		

Applicant's Signature	Date	Physician's Signature	Date
I hereby certify that the above information is true and complete to the best of my knowledge.		(Acknowledge review)	

### PHYSICIAN'S REPORT OF HEALTH EVALUATION

EXAMINING PHYSICIAN: Please review the applicant's history and complete this section of the report. Please comment on all positive answers. This information is strictly for the use of the Diocese of San Bernardino and will not be released without the applicant's consent.

APPLICANT'S LAST NAME	FIRST NAME	MIDDLE NAME	EXPLANATIONS:
Blood Pressure:		Pulse Rate:	
Height:	in.	Weight:	
		lbs.	
Corrected Vision Right Eye: 20/		Left Eye: 20/	

TESTS						EXPLANATIONS:
TUBERCULIN SKIN TEST:	Positive:		Negative:			
URINALYSIS:	Sugar:		Albumin:		Micro:	
HIV:		VDRL:		HEPB SER:		
CHEST X-RAY:						

#### SPECIAL CONSENT FOR DISCLOSURE:

I, \_\_\_\_\_, give written consent that \_\_\_\_\_, M.D., may write the results of my HIV test on this Confidential Health Form of the Diocese of San Bernardino, which form is part of my application process for entry into studies for the priesthood of the Roman Catholic Faith, and I consent that the present Director of Vocations, \_\_\_\_\_, may be informed of this result.

Applicant's Signature	Date
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