

St Vladimir's Orthodox Theological Seminary

MEDICAL INFORMATION FORM

I. This Section to be Completed by the Applicant

Full legal name _____
(First) (Middle)/(Maiden) (Last)

Permanent address _____

Telephone _____ Sex: [] Male [] Female

Marital status _____

In case of emergency notify: _____

Relationship _____

Address _____

Telephone _____

Family Medical History

Father's age/Age at death _____ Health/Cause of death _____

Mother's age/Age at death _____ Health/Cause of death _____

Brothers and/or sisters: (Age/health) _____

What members of your family have had the following medical problems?

Allergy _____ Hemophilia _____

Asthma _____ High blood pressure _____

Cancer _____ Kidney trouble _____

Diabetes _____ Mental disorder _____

Epilepsy, convulsions _____ Nervous disorder _____

Heart trouble _____ Tuberculosis _____

Do you have health insurance? _____

If so, specify carrier and coverage: _____

Will it continue while you are at the seminary? _____

Immunizations (Give approximate dates):

Smallpox _____ Tetanus _____

Diphtheria _____ Polio _____

Typhoid _____ Mumps _____

Date of last chest X-ray _____ Normal [] Abnormal []

Do you wear contact lenses? _____ Glasses? _____

Past illnesses or conditions (give approximate age or dates):

Allergy _____	Measles _____
Amoebic dysentery _____	Menstrual disorders _____
Asthma _____	Mumps _____
Chicken pox _____	Pleurisy _____
Diabetes _____	Pneumonia _____
Emotional _____	Polio _____
Epilepsy _____	Rheumatic fever _____
German measles _____	Scarlet fever _____
Hay fever _____	Skin trouble _____
Hepatitis _____	Stomach trouble _____
High/low blood pressure _____	Tuberculosis _____
Infectious mononucleosis _____	Typhoid fever _____
Kidney trouble _____	Venereal disease _____
Malaria _____	Whooping cough _____
Injuries, fractures _____	

Hospitalization(s):

Dates: _____	Diagnosis: _____
_____	_____
_____	_____

Have you ever discontinued study or work because of physical or mental illness? _____ If so, give dates and circumstances:

Do you have frequent colds or sore throat? _____

Have you had chronic and/or severe headaches during the past year? _____

To what extent do you use tobacco, alcohol, or non-prescription drugs? _____

Are you receiving medication now? _____ If so, please explain: _____

Do you have any apprehension in regard to your health _____

If you are presently under regular medical and/or psychological care by someone other than the examining physician completing the form below, please also ask that physician (or counselor or therapist) to submit a statement describing your capacity to pursue and complete a program of graduate study in theology.

To the best of my knowledge, the above information is complete and accurate.

Applicant's signature

Date

II. This Section to be Completed by the Examining Physician

Name of applicant _____

Height _____ Weight _____ Build _____

Pulse _____ Blood pressure _____

CLINICAL EVALUATION: *Please describe any abnormality to the right of the item*

	<i>Normal</i>	<i>Abnormal</i>	<i>Description</i>
Skull, scalp, face, neck, thyroid	_____	_____	_____
Nose and sinuses	_____	_____	_____
Mouth and teeth	_____	_____	_____
Throat and tonsils	_____	_____	_____
Ears	_____	_____	_____
Eyes	_____	_____	_____
Lungs and chest	_____	_____	_____
Heart	_____	_____	_____
Abdomen	_____	_____	_____
Anus and rectum	_____	_____	_____
Endocrine system	_____	_____	_____
Upper extremities	_____	_____	_____
Lower extremities, feet	_____	_____	_____
Genital-urinary system	_____	_____	_____
Spine, other musculo-skeletal	_____	_____	_____
Skin	_____	_____	_____
Lymphatic glands	_____	_____	_____
Neurologic	_____	_____	_____
Psychiatric (specify any known problem)	_____	_____	_____

Hgb.or Hct. _____

Urinalysis: Alb. _____ Sugar _____ Blood _____ Micro _____

Other lab work done: _____

General health of applicant: Excellent _____ Good _____ Fair _____

Any special limitations, or restrictions on physical activity? _____

Is the person a carrier of any communicable disease? _____

Other remarks: _____

Name of examining physician (please print) _____ Signature _____ Date _____

Address _____

Return this form to: Registrar, St. Vladimir's Seminary, 575 Scarsdale Road, Crestwood, NY 10707-1699