DIOCESE OF COVINGTON

MEDICAL HISTORY

RETURN TO:

Reverend Andrew L. Young
Vocation Promoter
Diocese of Covington
1125 Madison Avenue
Covington. KY 41011

THIS SECTION IS TO BE COMPLETED BY APPLICANT

Date: _____ ☐ College ☐ Pre-Theology ☐ Theology

Name: _____
Last Name First Name Middle Name

Address: _____
Complete Street Address City, State, Zip

Date of Birth: _____ Place of Birth: _____ Ethnic Background: _____
Mo/Day/Year City, State, Country

How long have you lived in the U.S.? _____years Social Security Number: _____

Health Insurance Company Name: _____

Policy Number: _____ Policy Holder Name: _____

Entering into: College: 1 2 3 4 Pre-Theology: 1 2 Theology: 1 2 3 4

In Case of an Emergency, Notify:

_____
Name Relationship

_____
Area Code Phone Number Street Address City, State, Zip

Family History:
Among your blood relatives is there any history or present illness of any of the following:

	Yes	No	Relationship
1. Cancer	_____	_____	_____
2. Heart Disease	_____	_____	_____
3. High Blood Pressure	_____	_____	_____
4. Stroke	_____	_____	_____
5. Tuberculosis	_____	_____	_____
6. Diabetes	_____	_____	_____
7. Nervous or Mental Condition	_____	_____	_____
8. Asthma or Hay Fever	_____	_____	_____
9. Seizures	_____	_____	_____
10. Alcoholism	_____	_____	_____
11. Drug Abuse	_____	_____	_____

Are your parents living? Father:____ Mother: ____ No. of brothers living ____ No. of sisters living _____

If deceased, give relationship and cause of death: _____

THIS SECTION IS TO BE COMPLETED AND SIGNED BY APPLICANT

Has your health been Good _____ Fair _____ Poor _____. If not good, explain: _____

Have you ever had or do you suspect you may have had the following: If yes, please explain

Check each Item	Yes	No	Explain	Check each Item	Yes	No	Explain
Anemia or other blood disease				Loss of arm, leg, finger, or toe			
Appendicitis, acute or chronic				Loss of memory or amnesia			
Arthritis, swollen or painful joints				Kidney disease, stones or blood in urine			
Asthma or shortness of breath				Malaria			
Boils				Meningitis			
Bone, joint or other deformity				Mononucleosis			
Chronic or frequent colds				Nervous or mental condition			
Chronic cough				Neuritis			
Cramps in legs				Pain or pressure in chest			
Diabetes				Painful or "trick" shoulder, knee, elbow			
Ear, nose or throat trouble, mastoids etc				Palpitation or pounding heart			
Eating disorder				Paralysis			
Epilepsy or seizures				Pneumonia			
Eye problems				Rheumatic Fever			
Foot trouble				Scarlet Fever			
Frequent indigestion				Severe tooth or gum trouble			
Frequent or painful urination				Sinus disease			
Gall bladder trouble or gall stones				Stomach, liver or intestinal trouble			
Hay fever				Soaking sweats, night sweats			
Headaches, frequent or severe				Skin disease or rashes			
Hearing loss				Thyroid trouble			
Heart disease				Tonsillitis			
Hernia or rupture				Tuberculosis			
Hepatitis or jaundice				Tumor, growth, cyst, cancer			
High or low blood pressure				Venereal disease			
Lameness				Vertigo, dizziness, fainting spells			

Have you ever:

	Yes	No	Date
Worn a brace or back support			
Been treated for alcoholism			
Been treated for drug abuse			
Bled excessively after surgery or tooth extraction			
Lived with anyone who had tuberculosis			
Coughed up blood			
Smoked or smoke now			
Do you have a regular exercise program			
Do you wear a seat belt while driving			

Current Medical Conditions: _____

Current Medication(s): _____

Past Hospitalizations, Surgeries: _____

BOTH SIDES OF THIS SECTION IS TO BE COMPLETED AND SIGNED BY PHYSICIAN

1. Age:		Height		Weight			
2. Build: Slender		Medium		Heavy		Obese	
3. Blood Pressure		S		D		Pulse	
4. Urinalysis:		Albumin		Sugar			
5. Hearing		Right	/15	Left	/15		
6. Vision		Right	20/	Left	20/		
7. Correction to		Right	20/	Left	20/		
8. Glasses		Contact Lenses		Color Vision			

Check each item in proper column	Normal	Abnormal	Note: Give details of each abnormality. Enter item number before comment.
1. Head, neck, face, and scalp			
2. Nose and sinuses			
3. Mouth, teeth, gingiva, and throat			
4. Ears-acuity, canals, drums			
5. Eye-acuity, lids, pupils, motions			
6. Lungs and chest			
7. Heart			
8. Vascular System (include varicosities)			
9. Abdomen and Viscere (include hernia)			
10. Ano-Rectal and Pilonidal			
11. Endocrine System			
12. Genito-Urinary System			
13. Upper Extremities			
14. Lower Extremities (include feet)			
15. Spine, other Musculo-Skeletal			
16. Skin and Lymphatics			
17. Neurological System			
18. Psychiatric (Personality deviation, etc.)			

19. Other

20. HIV

21. VDRL

22. Any special tests used for your clinical evaluation? (Blood, EKG, etc.)

23. Medicine allergies:

24. Other allergies:

Does student require injections for allergies? ☐ Yes ☐ no How frequent?

Over for Immunization record

IMMUNIZATION RECORD TO BE COMPLETED AND SIGNED BY PHYSICIAN

Students without proof of adequate immunity face exclusion from classroom attendance during any subsequent outbreak.

1. TETANUS/DIPTHERIA
   a) Completed primary series — Mo._____ Yr._____
   b) Received booster within last 10 years — Mo._____ Yr._____

2. M.M.R. (Measles, Mumps, Rubella) if not given as individual immunizations
   a) Dose 1 --- Immunized at 12 months or later — Mo._____ Yr._____
   b) Dose 2 --- Received after 1/1/80 (REQUIRED) — Mo._____ Yr._____

3. MEASLES (Rubeola)
   a) Had disease; confirmed by office record — Mo._____ Yr._____
   b) Born before 1957 and, therefore considered immune — Mo._____ Yr._____
   c) Has report of immune titer — Mo._____ Yr._____
   d) Immunized with live measles vaccine at 12 months or later — Mo._____ Yr._____

4. RUBELLA
   a) Has report of immune titer — Mo._____ Yr._____
   b) Immunized with vaccine at 12 months or later — Mo._____ Yr._____

5. MUMPS
   a) Had disease; confirmed by office record — Mo._____ Yr._____
   b) Immunized with vaccine at 12 months or later — Mo._____ Yr._____

6. POLIO
   a) Completed primary series — Mo._____ Yr._____

7. TUBERCULIN SKIN TEST
   All incoming students are required to have a PPD (Mantoux) skin test within the past year.
   a) Give date and results — Date_____ Result: Positive_____ Negative____mm
   b) Positive PPD – chest x-ray required — Date_____ Result of x-ray_____
   c) Had BCG vaccine – chest x-ray required if PPD not done — Date_____ Result of x-ray_____

Every college freshman student is required to enroll in the physical education program for two semesters. Check either A or B:

_____ A. This student may participate in a program of physical education, which includes such sports as basketball, soccer, swimming, gymnastics, tennis, handball, bowling and karate.

_____ B. This student should be enrolled in a restricted program of physical education. I make this recommendation for this reason:_____

Physician's Name:

Street Address:

City, State, Zip:

Phone Number:

Physician's signature: Date: