HEALTH REPORT
ON CANDIDATE FOR ST. BEDE ABBEY

Name _____ Age _____
Last First Middle

Home address _____ _____
Street City State Zip Phone

Birth _____ Social Security No. _____
Date Place

Personal Physician _____ _____
Name Phone

_____
Address

Health Insurance _____
Company Policy Number

This Health Report consists of two parts.

Part I is to be filled out by the candidate. It has three sections:

A. The medical history of the candidate's family
B. The candidate's personal medical history
C. The candidate's present state of health

The vocation director will answer any questions the candidate may have about any item in the report.

The candidate should answer to the best of his recollection questions which ask about specific names, times, etc., in the past. Sometimes it may be necessary to answer, "I don't know."

Not all items apply to each candidate; many are included because of the wide range in age and physical condition of applicants.

The information provided is confidential and will not be released to anyone without the consent of the candidate.

Part II is to be filled out by the examining physician.

With the consent of the candidate the examining physician may review the information provided in Part I.

Before sending his clinical evaluation to the Vocation Director the examining physician will inform the candidate of the results of his examination and, if it seems necessary or desirable, will review his findings personally with the candidate.

Date _____

Health Report on St. Bede Abbey candidate _____

PART I

A. Medical History of candidate's family

	Age if living	Condition of health	Occupation	Age at death	Cause of death
Father					
Mother					
Bro/Sis					
Bro/Sis					
Bro/Sis					
Bro/Sis					
Bro/Sis					
Bro/Sis					
Bro/Sis					

Indicate whether any of the following medical conditions has occurred among your close relatives (grandparents, parents, brothers, sisters). Mark "No" only if you are sure that none of these relatives has had the condition.

	Yes	Relative(s) with the Condition	No	Don't know
Heart Disease				
Chronic high or low blood pressure				
Cancer				
Diabetes				
Tuberculosis				
Epilepsy				
Alcoholism				
Allergies				
Asthma				
Stomach disorders				
Nervous disorders or mental illness				

You may add clarifying comments below if any of the above medical conditions or others not listed that seem to "run in the family".

Heath Report – Part I – Candidate _____

B. Candidate's Personal Medical History

1. List all serious physical injuries (e.g., broken bones, injured organs, etc.) that you have had and that have not required surgery.

2. List all surgeries you have undergone (e.g., tonsillectomy, appendectomy, hernia repair, etc.) and state as far as possible when and by whom the surgery was performed.

3. Indicate whether you have ever had any of the following:

	Yes	No		Yes	No
Scarlet fever			Unusual loss or gain of weight		
Measles			Insomnia		
Mumps			Gallbladder trouble		
Chicken pox			Serious dizzy or fainting spells		
Mononucleosis			Frequent anxiety		
Arthritis			Frequent depression		
Asthma			Frequent worry or nervousness		
Hay fever			Tuberculosis		
Sinusitis			Heart trouble		
Epilepsy			Stomach or intestinal trouble		
Cancer			Urinary disorders		
Hernia			Venereal disease		
Back problems					

Please comment below on any item in the above list that seems of special significance (e.g., because of its length or severity), especially if the problem continues to affect your present state of health.

4. Record of immunization and Tuberculin tests

	Year of Original Series	Year of last booster
Tetanus		
Polio		
Small pox		
Measles		
Other:		

5. Give the date of the latest Tuberculin test _____ and the result of it _____

6. Have you ever had an addiction to alcohol or other drugs? Yes _____ No _____ . If so, then please state briefly the nature and length of the addiction and how it was overcome.

7. Have you ever received psychological or psychiatric counseling or treatment? Yes _____ No _____ . If so, please state briefly the length of the treatment, and give the name of the psychologist or psychiatrist.

8. Have you been rejected for or discharged from military service because of physical, emotional or other reasons? Yes _____ No _____ If so, then please state briefly what the reasons were.

Health Report – Part I – Candidate _____

C. Candidate's present state of health

1. Do you presently have any physical handicaps or deformities? Yes _____ No _____. If so, then please state what they are.

2. Are presently under a doctor's care for the treatment or monitoring of any specific physical ailments? Yes _____ No _____. If so, then please indicate the ailment and treatment and give the name of the doctor if he is not your personal physician.

3. At present do you regularly take any prescription or over-the-counter medicine or drugs? Yes ____ No _____. If so, then please give their name, purpose and length of use.

4. Do you tend to be troubled much by:

	Yes	No
Nose bleeds		
Headaches		
Sore throat		
Head colds		
Upset stomach		
Constipation		
Diarrhea		
Black or tarry stools		
Blood in stools		

5. Do you have any allergies?

	Yes	No
Penicillin		
Sulfonamides		
Foods		
Other		

6. Please identify any food allergies_____

7. Please identify any other allergies _____

8. When was your last dental check-up? _____ Do you presently have any dental work that needs to be done? Yes _____ No _____. If so, then please indicate what it is and what plans there are for getting it done.

9. Do you have any special eating or sleeping requirements? Yes _____ No _____. If so, then please state what they are.

10. Do you tire easily? Yes ____ No _____ . If so, then what do you think may cause this?

11. Do you smoke? Yes _____ No _____. If so, then how much a day? _____

Heath Report – Part I – Candidate _____

B. Candidate's Personal Medical History (concluded)

12. Do you presently have any problems of addiction? Yes _____ No _____. If so, please state briefly the nature of the addiction and the efforts made to overcome it.

13. Are you aware of having any significant phobias? Yes ____ No _____. If so, then please state what they are.

14. Are you presently receiving psychological or psychiatric counseling or treatment? Yes _____ No_____. If so, then please state briefly the reason for and the length of the counseling or treatment and give the name of the psychologist or psychiatrist.

HEALTH EXAMINATION
PART II

Candidate _____ _____ _____

Last name *First name* *Middle name* *Age* *Date of examination*

To be filled in by the physician

Height: _____ **Body Structure** **Blood pressure**: Systolic: _____

Weight: _____ Slender Medium Heavy Obese Diastolic: _____

_____ _____ _____ _____ Pulse: _____

Vision
Right _____
Left _____

Glasses needed for:
____ Reading
____ Distance
____ All-purpose

Color vision _____

Hearing: (*Whispered voice at 10 feet*)
Right: Heard _____ Not heard _____
Left: Heard _____ Not heard _____
Enclose Audiogram if indicated

Urinalysis
S.G. _____ Alb. _____ Sugar _____
Microscopic if indicated _____

Tuberculin test (Tine, PPD)
Results _____
Chest X-ray report _____

Blood
Hgb. _____ Hct. _____ Serology _____
White Bl Ct _____ Differential _____
Report of VDRL _____
Exposure to AIDS Virus _____

CLINICAL EVALUATION

Check each item in appropriate column at right. Enter "N.E." if not evaluated.	Normal	Abnormal
1. Skull, scalp, face, neck, thyroid		
2. Nose and sinuses		
3. Mouth (tongue, gingivae, teeth)		
4. Throat and tonsils		
5. Ears (Int. and ext., canals)		
6. Eyes (pupils, E.O.M., conjunct.)		
7. Lungs and chest		
8. Heart (rhythm, sound, murmurs)		
9. Abdomen and viscera (include hernia)		
10. Anus and rectum (prostate if indicated)		
11. Endocrine system		
12. G-U system		
13. Upper extremities		
14. Lower extremities		
15. Feet (flat, pain, infection)		
16. Skin, other musculoskeletal		
17. Skin, lymphatic glands		
18. Neurological		
Comments on abnormalities may be made on the next page.		

Physician's Summary

(Overall comment on the candidate's health; special remarks concerning any of the detailed parts of the examination, especially abnormalities, which might call for particular attention; recommendations for future health care; etc.)

Date _____

Physician's Signature _____
Physician's Address _____
_____
_____
Phone _____

Please note: The physician is asked to inform the candidate of the results of his examination and, if it seems necessary, to review his findings with the candidate, before sending this report to:

Vocation Director
St. Bede Abbey
24 West U.S. Hwy Six
Peru, IL 61354