

**Holy Orders, Form 4:  
Medical Examination  
Diocese of Minnesota**

Required under the Canons of the Episcopal Church, Title III, Canon 4

To: The Rt. Rev. James L. Jelinek  
The Episcopal Diocese of Minnesota  
1730 Clifton Place, #201  
Minneapolis, MN 55403-3242

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Telephones (including Area Code): Home: \_\_\_\_\_ Work: \_\_\_\_\_

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/ZIP \_\_\_\_\_

Telephone (including Area Code): \_\_\_\_\_

Notify in case of illness/accident: Name: \_\_\_\_\_

Telephone: \_\_\_\_\_

# Medical Examination Form, Page 1 — Sample



## Medical Examination

Required Under TITLE III, CANON 4, Sec. 2e (“of Postulants for Holy Orders”), Under TITLE III, CANON 6, Sec. 3 (“of Ordination to Deacons”), Under TITLE III, CANON 12, Sec. 1c (“of Clergy Ordained by Bishops of Other Churches in Communion with This Church”), and Under TITLE III, CANON 22, Sec. 3b (“of the Election and Ordination of Bishops”) of the Constitution and Canons (1994) for the Government of the Episcopal Church.

Name		Date of Birth
Your Home Address		Phone Number/Fax Number
Marital Status	Children and Ages	
Notify in Case of Illness		Phone Number/Fax Number
Personal Physician	Physician's Address	Phone Number/Fax Number

Please answer all questions below “Yes” or “No”; provide full details in space at bottom for any questions answered “Yes.”

Have You	Yes	No
1. Ever been rejected or paid extra money for insurance?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ever received Workmen's Compensation or other disability benefits?	<input type="checkbox"/>	<input type="checkbox"/>
3. Been rejected for employment on account of any physical or mental condition?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever received prescription drugs for mental illness or substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever been a patient in a hospital?	<input type="checkbox"/>	<input type="checkbox"/>
6. Had any accidents, injuries or operations or contemplate any operation?	<input type="checkbox"/>	<input type="checkbox"/>
7. Received disability benefits or medical leave for any medical/psychiatric condition?	<input type="checkbox"/>	<input type="checkbox"/>
8. Had your medical or psychiatric fitness for a job or educational studies questioned by a supervisor or a supervising institution?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever left school or any position because of ill health?	<input type="checkbox"/>	<input type="checkbox"/>
10. Lost time from work or school in the past three years for medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>

Provide *full details* here for all questions answered “Yes.” *Full details* include the condition, dates and durations. List the question number when answering. Use additional sheets if necessary.

# Medical Examination Form, Page 2 — Sample

Check the appropriate box for the disorders you have or have had in the past.

	Yes	No		Yes	No
<b>Infectious Diseases</b>			<b>Respiratory System</b>		
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Dysentery (Chronic)	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Infantile Paralysis (Polio)	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Skin diseases or eczema	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	Chronic hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Chills	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
Lymph node enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco use	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
<b>Heart and Blood Vessels</b>			<b>Nervous System</b>		
High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epileptic or other fits	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Pain in chest	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Mental or nervous diseases (family)	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Mental or nervous diseases (self)	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	Visual problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia or blood disease	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Coagulation disorder	<input type="checkbox"/>	<input type="checkbox"/>	Ringing ears, hearing difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Weakness of limbs	<input type="checkbox"/>	<input type="checkbox"/>
<b>Digestive System</b>			<b>Miscellaneous</b>		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Lymphoma or Other Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or sugar disease (family)	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or sugar disease (self)	<input type="checkbox"/>	<input type="checkbox"/>
Bloody stools	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Marked over or underweight	<input type="checkbox"/>	<input type="checkbox"/>	Foot problems	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>
Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Hernia (rupture)	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to any food, medicine or injection	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>
<b>Genitourinary System</b>			Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Use of nicotine on daily basis in the past five years.	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been a habitual user of any habit forming drugs or received treatment for alcoholism or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Prostate disease	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had any illnesses (mental or physical) or accidents other than those mentioned?	<input type="checkbox"/>	<input type="checkbox"/>
Bladder disease	<input type="checkbox"/>	<input type="checkbox"/>			
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>			
Pain in passing urine	<input type="checkbox"/>	<input type="checkbox"/>			
Urinary tract infection	<input type="checkbox"/>	<input type="checkbox"/>			

I hereby declare that my answers to the above questions are full and true.

Signed at \_\_\_\_\_ in my presence,  
this \_\_\_\_\_ day of \_\_\_\_\_, 19 \_\_\_\_\_.

\_\_\_\_\_  
(Full signature of applicant)

\_\_\_\_\_  
(Physician)

# Medical Examination Form, Page 3 — Sample

Outline for Physical Examination			
1. (a) How long have you known applicant _____	(b) in what relationship? _____		
2. (a) height without shoes: _____	(b) weight: _____		
<b>Vital Signs</b>			
Temperature _____	Pulse _____	Respiration _____	Blood Pressure _____ (arm, R or L position)

**Physical Examination: Check for within normal limits. Note positive findings in the space below.**

<p><b>Head</b></p> <p><u>Eyes:</u> vision <input type="checkbox"/>  conjunctivae and sclerae <input type="checkbox"/>  pupils size <input type="checkbox"/>  reaction <input type="checkbox"/>  equality <input type="checkbox"/>  appearance <input type="checkbox"/></p> <p><u>Ears:</u> hearing <input type="checkbox"/>  air and bone conduction <input type="checkbox"/>  appearance of tympanic membranes <input type="checkbox"/></p> <p><u>Nose:</u> obstruction to breathing <input type="checkbox"/>  septal deviation and/or perforation <input type="checkbox"/>  discharge <input type="checkbox"/></p> <p><u>Mouth:</u> sores <input type="checkbox"/>  dental status <input type="checkbox"/>  appearance and palpation of mucosa, tongue, gums, floor of mouth <input type="checkbox"/>  appearance of tonsils, pharynx <input type="checkbox"/>  appearance &amp; movement of uvula, palate <input type="checkbox"/>  gag reflex <input type="checkbox"/></p>	<p><b>Lymph Nodes</b></p> <p>Enlargement, consistency and/or tenderness of cervical, axillary, epitrochlear, popliteal, and inguinal glands <input type="checkbox"/></p> <hr/> <p><b>Chest</b></p> <p>Appearance and function of chest wall <input type="checkbox"/></p> <p><u>Breasts:</u> appearance, asymmetry, tenderness, masses, nipple discharge <input type="checkbox"/></p> <p><u>Lungs:</u> type of respiration, character of breath sounds; presence of rales, rhonchi, wheezes or rubs <input type="checkbox"/></p> <hr/> <p><b>Heart</b></p> <p>Apex location, precordial movements or thrills <input type="checkbox"/></p> <p><u>Auscultation:</u>  heart sounds: S1, S2, S3, S4 <input type="checkbox"/>  presence of murmurs, clicks, rub, split sounds <input type="checkbox"/>  radiation of murmurs <input type="checkbox"/></p>
<p><b>Neck</b></p> <p>Palpable masses <input type="checkbox"/>  Thyroid <input type="checkbox"/>  Location of trachea <input type="checkbox"/>  Venous engorgement <input type="checkbox"/>  Bruits <input type="checkbox"/>  Flexibility <input type="checkbox"/></p>	<p><b>Pulses</b></p> <p>Carotids <input type="checkbox"/>  Brachials <input type="checkbox"/>  Radials <input type="checkbox"/>  Femorals <input type="checkbox"/>  Dorsalis pedis <input type="checkbox"/>  Posterior Tibials <input type="checkbox"/></p>

**Summary of positive findings:**

# Medical Examination Form, Page 4 — Sample

## Outline for Physical Examination

(con't from previous page)

<p><b>Spine</b></p> <p>Mobility <input type="checkbox"/></p> <p>Tenderness <input type="checkbox"/></p> <p>Curvature <input type="checkbox"/></p> <hr/> <p><b>Abdomen</b></p> <p>Appearance (distended, flat, scaphoid) <input type="checkbox"/></p> <p>Abnormal movements <input type="checkbox"/></p> <p>Dilated veins <input type="checkbox"/></p> <p>Striae <input type="checkbox"/></p> <p><b>Auscultation:</b>    bowel sounds <input type="checkbox"/></p> <p>                          bruits <input type="checkbox"/></p> <p>                          rubs <input type="checkbox"/></p> <p><b>Percussion:</b>    distention <input type="checkbox"/></p> <p>                          organ size (liver, spleen, bladder) <input type="checkbox"/></p> <p><b>Palpation:</b>      resistance <input type="checkbox"/></p> <p>                          tenderness <input type="checkbox"/></p> <p>                          rebound <input type="checkbox"/></p> <p>                          organs (liver, spleen, bladder) <input type="checkbox"/></p> <p>                          masses <input type="checkbox"/></p> <p>                          epigastric or incisional hernia <input type="checkbox"/></p> <hr/> <p><b>Neurological</b></p> <p>Mental status <input type="checkbox"/></p> <p>Cranial nerves <input type="checkbox"/></p> <p>Cerebellar function <input type="checkbox"/></p> <p>Muscle strength <input type="checkbox"/></p> <p>Reflexes <input type="checkbox"/></p> <p>Gait and station <input type="checkbox"/></p> <p>Rapid Sensory exam including vibratory <input type="checkbox"/></p>	<p><b>Extremities</b></p> <p>Skin color <input type="checkbox"/></p> <p>Temperature <input type="checkbox"/></p> <p>Texture <input type="checkbox"/></p> <p>Varicosities <input type="checkbox"/></p> <p>Clubbing <input type="checkbox"/></p> <p>Edema <input type="checkbox"/></p> <p>Joint Motions <input type="checkbox"/></p> <p>Muscular Abnormalities <input type="checkbox"/></p> <p>Circumference <input type="checkbox"/></p> <hr/> <p><b>Genital , Prostate or Pelvic Examination</b></p> <p>List any abnormal findings:</p>  <hr/> <p><b>Rectal Exam and Stool Sample</b></p> <p>List positive findings:</p>  <hr/> <p><b>LABORATORY</b></p> <p>CBC _____</p> <p>Fasting Chem Profile _____</p> <p>U/A _____</p> <p>EKG (if indicated) _____</p> <p>PPD _____</p>
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On the basis of your examination, is the candidate free from any medical condition or other impediment that would render him/her unsuitable for the tasks of ordained ministry? (If you have any confidential information that would render the candidate unacceptable, please so indicate here and forward details to the Bishop by confidential communication.)

This report should be mailed by examiner directly to the Bishop, and the information should be treated as strictly confidential.

\_\_\_\_\_  
 Examiner's Signature M.D.

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Phone Number/Fax Number