NOTRE DAME SEMINARY
CANDIDATE MEDICAL FORM

SEMINARIAN:

Complete page one of this form before your exam. Take the completed form to the appointment.

Seminarian's Name _____ Date _____

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) you are currently taking:

_____

_____

Do you have any allergies? ☐ No ☐ Yes (If yes, list specific allergy and reaction.)

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Complete the following section with a checkmark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: ***Have you…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infection Other_____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Ever become ill while exercising in the heat?		
6. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: ***Have you…***	**YES**	**NO**
7. Had headaches with exercise?		
8. Ever had a head injury or concussion?		
9. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Noticed or been told you have a curved spine or scoliosis?		
11. Had any problem with your eyes (vision) or had a history of an eye injury?		
12. Been prescribed glasses or contact lenses?		
HEART/LUNGS: ***Have you...***	**YES**	**NO**
13. Ever used an inhaler or taken asthma medicine?		
14. Ever had the doctor say you have a heart problem? If so, check all that apply: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ Other:_____		
15. Had a heart test? (For example, ECG/EKG, echocardiogram)?		
16. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded during or after exercise?		
17. Had discomfort, pain, tightness or chest pressure during exercise?		
18. Felt your heart skip beats during exercise?		
BONE/JOINT: ***Have you...***	**YES**	**NO**
19. Had a broken or fractured bone, stress fracture, or dislocated joint?		
20. Had an injury to a muscle, ligament, or tendon?		
21. Had an injury that required a brace, cast, crutches, or orthotics?		
22. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
23. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: ***Have you...***	**YES**	**NO**
24. Had any rashes, pressure sores, or other skin problems?		
25. Ever had herpes or a MRSA skin infection?		
VISION: ***Have you...***	**YES**	**NO**
26. Need of glasses or contact lenses to have correct vision?		
27. Been diagnosed as being color blind		

GENITOURINARY: ***Have you...***	**YES**	**NO**
28. Had groin pain or a painful bulge or hernia in the groin area?		
29. Had a history of urinary tract infections or kidney stones?		
DENTAL:	**YES**	**NO**
30. Have you had any pain or problems with your gums or teeth?		
31. Last dental visit: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Have you...***	**YES**	**NO**
32. Been told you have a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
33. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
34. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
35. Used (or currently use) tobacco?		
36. Used (or currently use) alcohol?		
37. Used (or currently use) drugs?		
CHILDHOOD DISEASES: **(CIRCLE ALL THAT APPLY)**		
Chicken Pox Diphtheria Rubella (3-Day or German) Rubeola (Measles) Mumps Polio Whooping Cough		
FAMILY HEALTH:	**YES**	**NO**
38. Is there a family history of the following? If so, check all that apply: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ Sickle cell trait or disease Other_____		
39. Is there a family history of any of the following heart-related problems? If so, check all that apply: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ Other_____		
40. Has any family member / relative died of heart problems before age 50?		
41. Has any family member / relative died of an unexpected/ unexplained sudden death before age 50? Explain:		

I hereby certify that to the best of my knowledge, all of the information is true and complete. I authorize the Rector of Notre Dame Seminary, the Admissions Committee, and the appropriate diocesan officials (bishop/director of vocations) access to my Medical Form, unless I revoke it in writing.

Signature of Seminarian_____ Date_____

SEMINARIAN'S NAME_____ **THIS PAGE IS TO BE COMPLETED AND SIGNED BY THE ATTENDING PHYSICIAN:**

SEMINARIAN'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes ☐ No ☐

Age: _____ Build (CIRCLE ONE): Slender Medium Heavy Obese	CHECK ONE NORMAL	ABNORMAL *	*ABNORMAL FINDINGS / EXPLANATIONS / RECOMMENDATIONS / REFERRALS
Height: ( ) inches			
Weight: ( ) pounds			
Urinalysis: Albumin Sugar			
Pulse: ( )			
Blood Pressure: (/)			
Hair, Neck, Face, & Scalp			
Skin (also noting Scars & Tattoos)			Reason & Location of Scars:
Eyes/Vision—Acuity, Lids, Pupils, Motion			
Ears/Hearing—Acuity, Canals, Drums			
Nose & Sinuses			
Mouth, Teeth, Gingiva, & Throat			
Lymph Glands			
Heart & Vascular (Include Varicosities)			
Lungs & Chest			
Spine (Scoliosis)			
Neuromuscular System			
Upper & Lower Extremities			
Abdomen			
Urinary System			
Other			

Genitalia (THE FOLLOWING CANNOT BE DEFERRED AND MUST BE EXAMINED & ATTESTED TO BY THE PHYSICIAN)

Hernia YES NO

Biological Male Penis: YES NO

Testicles: TWO ONE NONE OTHER

IF OTHER THAN TWO, EXPLAIN:_____

Every seminarian is required to maintain a program of physical fitness. Check the following box if applicable:

☐ **This student may participate in a program of physical fitness, which may include such sports as football, basketball, soccer, swimming, tennis, baseball. If not, explain in full:**

REQUIRED TESTING

Please attach to this completed form the results of the blood analysis INCLUDING HIV and drug testing.

Please attach any other pertinent medical notes or information to this form.

Print name of physician_____

Print physician's office address_____ **Phone**_____

Signature of physician_____ **Date of Exam** _____, **20**_____

HEALTH CARE PROVIDERS: ***Please photocopy immunization history from seminarian's record – OR – insert information below.***

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Tuberculosis Skin Test	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
COVID Vaccine (optional)	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Meningitis/Hepatitis B Disclosure (Louisiana Law demands disclosure of status of these immunizations for all resident students.)					
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Verify immunizations meet Louisiana requirements	☐ Tetanus/Diphtheria (booster every 10 years)		☐ Polio (series of 3)		☐ MMR (2 injections after age of 12 months)
Other Vaccines: (Type and Date)					

IMMUNIZATION EXEMPTION(S):

Medical ☐ Date Issued:_____ Vaccine & Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Vaccine & Reason: _____ Date Rescinded:_____

Medical ☐ Date Issued:_____ Vaccine & Reason: _____ Date Rescinded:_____