



CATHOLIC
DIOCESE
OF WICHITA

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424 NORTH BROADWAY • WICHITA, KANSAS 67202

OFFICE OF VOCATIONS
PHONE: (316) 269-3900 • FAX: (316) 269-3902

MEDICAL HISTORY OF APPLICANT FOR THE PRIESTHOOD

Please fill in this form by typing in the spaces provided. Carefully review your responses before printing this and the other forms in this packet. You will not be able to electronically save the information filled on this form. Kindly consider printing an extra copy for your own records.

Last Name First Name Middle Name

Family History

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

	Yes	No	Relationship		Yes	No	Relationship
Asthma/Hay Fever	_____	_____	_____	Cancer/Type	_____	_____	_____
Convulsions	_____	_____	_____	Death before 50	_____	_____	_____
Diabetes	_____	_____	_____	Elevated Cholesterol	_____	_____	_____
Heart Disease	_____	_____	_____	Hypertension/Stroke	_____	_____	_____
Kidney Disease	_____	_____	_____	Mental Illness	_____	_____	_____
Tuberculosis	_____	_____	_____	Nervous Disorder	_____	_____	_____

Have you ever had or do you suspect that you may have (if yes, please explain):

Check each item	Yes	No	Explain
ADHD	_____	_____	_____
Allergies/Hay Fever	_____	_____	_____
Alcohol Abuse/Drug Abuse	_____	_____	_____
Anemia or other blood disease	_____	_____	_____
Arthritis, swollen or painful joints	_____	_____	_____
Asthma	_____	_____	_____
Bone, joint, or other musculoskeletal problems	_____	_____	_____
Cancer/Lukemia	_____	_____	_____
Chicken Pox	_____	_____	_____
Chronic Cough/Shortness of Breath	_____	_____	_____
Colitis	_____	_____	_____
Constipation	_____	_____	_____
Convulsions/Seizures	_____	_____	_____
Depression	_____	_____	_____
Diabetes	_____	_____	_____
Disability/Handicap	_____	_____	_____
Ear, nose, or throat trouble	_____	_____	_____
Eating disorder	_____	_____	_____
Eye Disease	_____	_____	_____
Gallbladder Trouble	_____	_____	_____
Frequent/Painful Urination	_____	_____	_____
Head Trauma	_____	_____	_____
Headaches, frequent or severe	_____	_____	_____
Heart Disease/Problems	_____	_____	_____
Hernia	_____	_____	_____
Hepatitis/Jaundice	_____	_____	_____
High or low blood pressure	_____	_____	_____

MEDICAL HISTORY (CONT.)

Measles	_____	_____	_____
Meningitis	_____	_____	_____
Mononucleosis, Infectious	_____	_____	_____
Mumps	_____	_____	_____
Pain /Pressure in chest	_____	_____	_____
Pneumonia	_____	_____	_____
Paralysis	_____	_____	_____
Polio	_____	_____	_____
Psychological Counseling	_____	_____	_____
Rheumatic Fever	_____	_____	_____
Rubella	_____	_____	_____
Scarlet Fever	_____	_____	_____
Sexually Transmitted Infections	_____	_____	_____
Severe Tooth/Gum Trouble	_____	_____	_____
Sinus Trouble	_____	_____	_____
Skin Disease/Rashes	_____	_____	_____
Sleep Problems	_____	_____	_____
Spleen, surgical removal	_____	_____	_____
Stomach, liver or intestinal disorders	_____	_____	_____
Thyroid Trouble	_____	_____	_____
Tuberculosis	_____	_____	_____
Ulcers	_____	_____	_____
Whooping Cough	_____	_____	_____
Other	_____	_____	_____

Serious illness or hospitalizations (List): _____

Previous surgeries or injuries (broken bone, head injury): _____

Current prescription and OTC medications: _____

Allergies to drugs, food, plants, other: _____

History of medications taken: _____

1. Have you ever been unable to take physical education or participate in sports because of your health? Yes No

If yes, please explain. _____

2. Have you been denied life insurance, rejected for military service or refused employment because of your health? Yes No

If yes, please explain. _____

3. Have you consulted, been treated, or been counseled by a physician or clinic in the past five years? Yes No

If yes, please explain. _____

4. Have you ever had any serious illness, injury, or operation not listed above? Yes No

If yes, please explain. _____

5. Have you had a chest x-ray? If yes, please give date and results. _____ Yes No

6. When is the last time you visited your dentist? _____

7. When is the last time you visited an eye doctor? _____

8. Have you ever visited a medical specialist? _____ Yes No

If yes, please explain. _____

I verify that the information provided on this form is complete and accurate to the best of my knowledge.

Signature _____

Date _____