



**PART II: MEDICAL EXAMINER'S REPORT**

*To be completed by the physician*

1. General Appearance \_\_\_\_\_

2. Personal Hygiene \_\_\_\_\_

3. Height: \_\_\_\_\_ Weight: \_\_\_\_\_

4. Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_ (Give readings before and after exercise)

Temperature \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

6. Vision \_\_\_\_\_

7. Hearing \_\_\_\_\_

8. Condition of mouth and throat: \_\_\_\_\_

\_\_\_\_\_

9. Evidence of varicosity \_\_\_\_\_ Hernia \_\_\_\_\_

10. Evidence of disease or abnormalities of:

Heart \_\_\_\_\_

Lungs \_\_\_\_\_

Thorax \_\_\_\_\_

Spine \_\_\_\_\_

Genitalia \_\_\_\_\_

11. Evaluate nervous and mental condition: \_\_\_\_\_

\_\_\_\_\_

Laboratory Tests (**required**) pap Smear (for all women) \_\_\_\_\_ Mammogram \_\_\_\_\_  
PSA (for men over 50) \_\_\_\_\_ Cholesterol \_\_\_\_\_  
Fasting Blood Sugar \_\_\_\_\_

**SUMMARY OF FINDINGS AND RECOMMENDATIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Physician (Type or print) \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

**Signature of Physician:** \_\_\_\_\_

Please send the completed form to Registrar of Deacons:

**Jean Forbes, Registrar of Deacons**  
**1569 Wedgewood Way**  
**Wooster, OH 44691**