



# CHILD EVANGELISM FELLOWSHIP OF EASTERN PENNSYLVANIA, INC.

P.O. BOX 4375 ♦ HARRISBURG, PA 17111-0375  
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Please return this form to:

## STAFF PHYSICAL REPORT

(Please print plainly.)

Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

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

Social Security No. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### PAST MEDICAL HISTORY

1.	Family History	Who?	Age Started	Who?	Age Started
	Allergies			Kidney Disease	
	Cancer			Nervous Disorder	
	Diabetes			Rheumatism	
	Endocrine (as goiter)			Tuberculosis	
	Heart Disease			Any other	
	High Blood Pressure				

2. **Childhood Background** (Check the ones that apply.)

**Birth:** Normal \_\_\_\_\_ Caesarian \_\_\_\_\_ Forceps \_\_\_\_\_  
**Childhood:** Healthy \_\_\_\_\_ Frequently Ill \_\_\_\_\_ Feeding Problems \_\_\_\_\_

3. **Past Diseases** (Have you had any of the following diseases or symptoms? If you have, please place the approximate age beside the disease. **Example:** Allergy - (To penicillin) - 14.)

AIDS	Malaria
Allergies	Measles
Anemia	German Measles
Bacterial Meningitis	Mumps
Cancer	Pleurisy
Cardiac Abnormality	Pneumonia
Chickenpox	Poliomyelitis
Diphtheria	Rheumatic Fever
Dysentery	Rheumatic Heart Disease
Encephalitis	Scarlet Fever
Epilepsy	Tonsillitis
Goiter	Tuberculosis
Hepatitis	Typhoid or Paratyphoid
Jaundice	Whooping Cough
Kidney Disease	

4.*	Medical and Surgical Facts	Yes	No
	Have you had a chest x-ray? If yes, give date of last one _____	<input type="checkbox"/>	<input type="checkbox"/>
	Has there ever been any spitting of blood?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you ever had pus, blood, or sugar in your urine?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you ever had pus, blood, or mucus in your bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you ever had a brain concussion or skull fracture?	<input type="checkbox"/>	<input type="checkbox"/>
	Any other accidents? (Give pertinent facts.)	<input type="checkbox"/>	<input type="checkbox"/>
	Have you had any operations?	<input type="checkbox"/>	<input type="checkbox"/>

(List operations and date of operations on a separate sheet.)

**PRESENT MEDICAL HISTORY**

**5.\* Do you now have any of the following?**

	Yes	No		Yes	No
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Neuritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Back	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Abnormality	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Joints	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Pain in Chest	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Pulse	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Flat Feet	<input type="checkbox"/>	<input type="checkbox"/>	Significant Weight Change	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Head / Chest Colds	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Swollen Feet	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers of the Mouth	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>			
Hernia	<input type="checkbox"/>	<input type="checkbox"/>			
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<b>Women Only:</b>		
Kidney or Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>

**6.\* General Considerations**

	Yes	No
Have you been let go from a job because of a nervous condition?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any physical handicaps not already mentioned that would hinder you from serving in the position for which you are applying? <i>If yes, explain:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have allergies to any food? <i>If yes, list them:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any dietary requirements which are medically prescribed? <i>If yes, list them:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking any prescribed medications? <i>If yes, list them:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>

**\*Where you have answered YES in #4, #5, and # 6, give details. Use a supplementary sheet if necessary.**

**7. Immunizations – Date of last immunization**

Small Pox	_____	Poliomyelitis ( <i>Injections</i> )	Date of all: _____
Diphtheria	_____		_____
Pertussis	_____		_____
Tetanus	_____	Poliomyelitis ( <i>oral</i> )	_____
( <i>Toxoid or Antitoxin, if known</i> )		( <i>Give type, if known</i> )	_____
( <i>Toxoid or Antitoxin, if known</i> )		( <i>Give type, if known</i> )	_____