

NOTRE DAME SEMINARY
2901 S. Carrollton Avenue
New Orleans, LA 70118-4391

A CERTIFICATE OF HEALTH

To be completed by applicant
Please return this form upon completion to the Rector's Office

Name: _____ **Age:** _____ **Sex:** _____

Height: _____ **Weight:** _____ **General Health:** ___ **Good** ___ **Fair** ___ **Poor**

MEDICAL HISTORY

Explanation of Positive Answers

Have you ever been under treatment or advised to undergo treatment by a health care provider for:

1. Seizure disorder, mental illness or significant adjustment problems, speech problems, significant learning disabilities, or any other neurologic problems Yes No
2. Cardiovascular disease, high blood pressure, mitral valve prolapse Yes No
3. Pulmonary disease including asthma, chronic bronchitis, tuberculosis, pneumonia, unusual shortness of breath Yes No
4. Significant gastrointestinal disorders including ulcer disease, inflammatory bowel disease, gall bladder disease Yes No
5. Significant urinary tract disease including kidney stones, urinary tract infections, sexually transmitted diseases Yes No
6. Chronic or recurrent allergic problems, recurrent sinusitis, oral surgery, hearing difficulty Yes No
7. Drug allergies or unusual sensitivity to a medication Yes No

MEDICAL HISTORY cont'd.

Explanation of positive answers

- 8. Significant musculoskeletal disease including collagen diseases (lupus, rheumatoid arthritis, etc), degenerative or traumatic arthritis or or permanent disability, back problems Yes No

- 9. Surgery or hospitalization for any problem not listed previously Yes No

- 10. Significant endocrine dysfunction including diabetes, thyroid disease, and adrenal dysfunction Yes No

- 11. Have you ever been treated for alcohol or substance abuse or participated in a twelve step recovery program Yes No

- 12. Are you aware of any other health problems other than those listed Yes No

- 13. Do you smoke Yes No

- 14. Are you currently receiving care from a health care provider Yes No

- 15. Have you ever been denied life insurance, the opportunity to serve in the military service, or been asked to withdraw from high school, college, graduate school or any other educational program because of health problems (including mental health) Yes No

Name and address of primary care physician:

Name

Address

City

State

Zip

I certify that the information given by me on this questionnaire is correct to the best of my knowledge.

Signature

Date