FRANCISCAN VOLUNTEER MINISTRY
P.O. Box 29276 Philadelphia, PA 19125 215/427-3070 Fax: 215/427-3059 e-mail: fvmpd@aol.com

MEDICAL HISTORY

This form is to be filled out by the applicant. A physician's signature is not necessary on this form. A physician's signature will be required on another form in the application process.

Applicant:
Name _____

Address _____

City _____ State _____ Zip _____ Phone (___)_____

Personal Doctor:
Name _____

Address _____

City _____ State _____ Zip _____ Phone (___)_____

Medical Insurance:
Are you covered by medical insurance? _____ If yes, please fill out the following information.
Name of Company _____

Address _____

City _____ State _____ Zip _____ Phone (___)_____

ID Number _____ Group Number _____

Coverage Code _____

Medical History:
1. Are you under medical treatment or taking any medications? _____ If yes, please explain.

_____

_____

2. Is there any illness in your family history that might be helpful for us to know?

_____

_____

_____

3. Have you ever been treated or are you now being treated for alcoholism or drug addiction? _____ If yes, please explain.

_____

_____

_____

4. Do you smoke? _____ If yes, what do you smoke: Cigarettes ____ Pipe____ Cigars____ And how often do you smoke?_____

5. Please indicate any counseling or psychotherapy that you have received and its impact on your life now. This information does not of itself determine acceptance into the Franciscan Volunteer Ministry, but can help us to understand how you have dealt with significant issues or events in your life. Please include the name, address and telephone number of the counselor or therapist and whether you authorize him/her to fill out a written report for the Franciscan Volunteer Ministry. (Please use an additional sheet if necessary.)

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The information on this form is accurate to the best of my knowledge:

Applicant's Signature _____ Date _____