

MEDICAL EVALUATION FORM
(Kindly fill all blanks LEGIBLY)

Applicant : _____ Age: _____ Gender: _____

Address : _____

Dear Dr. _____
Name of Physician

The above-named person has applied to adopt a child. In order to adopt, the applicant should have good physical and mental health. Kindly examine the applicant and give us a report of his/her present health condition.

Date of examination: _____

MEDICAL HISTORY OF APPLICANT:

How long has this person been under your care: _____

Describe this person's general physical health: _____

Does he/she have a history of hereditary disease or congenital abnormality? If there is /are, what is/are this/these? _____

Does applicant have any history of the following? If yes, please describe:

Tuberculosis : _____

Epilepsy : _____

Asthma : _____

Mental Illness : _____

Nervous Disorders/Neuroses: _____

Cancer : _____

Diabetes : _____

Venereal Disease: _____

Allergies : _____

Glandular/Hormonal/Enzymatic Disturbance (Specify): _____

Serious Illness : _____

Surgery : _____

Handicaps : _____

Impaired Sight (Extent): _____

Defective Hearing (Extent): _____

Speech Defects (Describe): _____

List any Psychotherapy/Counseling Utilized (Date, reason, Prognosis) _____

Other (Describe) : _____

PHYSICAL EXAMINATION OF APPLICANT:

Eyes : _____ Heart : _____ Ears : _____

Lungs : _____ Height : _____ Nose : _____

Abdomen: _____ Weight : _____ Throat : _____

Spine : _____ Skin : _____

EXAMINATION/TEST/S GIVEN TO APPLICANT:

Blood Pressure (Date and Findings): _____

Urinalysis (Date and Findings): _____

Serology for Syphilis (Date and Findings): _____

TB Tine Test (Date and Findings): _____

Is there a history of miscarriage or stillbirth (Give dates, etc.) _____

How long has applicant attempted to become pregnant? _____

Is the applicant under current treatment for childlessness? (Specify) _____

Is any further treatment recommended? _____

What is the applicant's prognosis for pregnancy (for female applicant)? _____

What is the applicant's prognosis for fathering a birth child (for male applicant)? _____

Has any operation, x-ray or radium treatment rendered applicant sterile/ if yes, specify the reasons for such treatments: _____

Is the applicant under medication/s? What is/are this/these? Dosage? Frequency of intake? For what reason/s? _____

Has fertility study been made? _____

Tubal Patency (Date and Findings) _____

Ovulation Studies (Date and Findings) _____

Sperm analysis (Date and Findings) _____

Surgery/ies/Others (Describe) (Date and Findings) _____

Is there any health condition which would render the applicant unable to give proper care to a child?

Is there any health condition which would affect the stability of the home situation in the future?

Basing on your overall assessment of the health of the applicant, is/are there any reason/s for you not to recommend the applicant as a prospective adoptive parent? _____

Signature of the Examining Physician

Name of the Physician (Typed)

Address of Physician

Date

City/State/Zip Code