

# **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 : \_\_\_\_\_

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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) \_\_\_\_\_

Others (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 any 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 Examining Physician

\_\_\_\_\_  
Name of Physician (Typed)

\_\_\_\_\_  
Address of Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
City/State/Zip Code