GENERAL PHYSICAL EXAMINATION FORM

THIS FORM MUST BE COMPLETED BY YOUR FAMILY PHYSICIAN AND WILL NOT BE ACCEPTED FROM AN URGENT CARE FACILITY.

This medical report is important in helping us get a total picture of the qualification of the adopting parent(s). You are kindly requested to complete this form. Please legibly print or type all information.

PATIENT NAME: **DOB:**

MEDICAL HISTORY

IS THERE A HISTORY OF:	Circle One		***IF YES, PLEASE EXPLAIN BELOW*** *(provide dates and outcome of treatment):*
Alcoholism/history of substance abuse	Yes	NO	
Arthritis	Yes	No	
Asthma	Yes	No	
Diabetes	Yes	No	
Epilepsy	Yes	No	
Genetic Disease	Yes	No	
Glandular disturbance	Yes	No	
Handicap	Yes	No	
Heart Disease	Yes	No	
Liver Disease	Yes	No	
Lung Disease	Yes	No	
Neuropathy	Yes	No	
Surgical operations	Yes	No	
Thyroid Disorder	Yes	No	
Tuberculosis	Yes	No	
Tumor	Yes	No	
Cancer	Yes	No	
Mental Illness	Yes	No	
Other Communicable diseases	Yes	No	

PHYSICAL EXAMINATION

Height _____ Inches / meters (*circle one*)

Weight _____ Pounds / kilograms (*circle one*)

BMI _____

Blood Pressure __________

Vision: ________(L) __________(R)

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Exam	Circle One:		*If Abnormal, please explain below* (provide dates and outcome of treatment):
Hearing (Right)	Normal	Abnormal	
Hearing (Left)	Normal	Abnormal	
Heart	Normal	Abnormal	
Liver	Normal	Abnormal	
Lungs	Normal	Abnormal	
Lymphatic System	Normal	Abnormal	
Thyroid	Normal	Abnormal	
Nervous System	Normal	Abnormal	

LAB TEST RESULTS

Test & Test Dates (Must be less than 12 months old)		Circle One		If Abnormal, please explain (provide dates and outcome of treatment):
Urinalysis Routine Urine Test	Date of Test: ____________	Normal	Abnormal	
TB/Chest X-Ray	Date of Test: ____________	Normal	Abnormal	

MEDICATIONS

Is the patient taking any prescription medication? (*circle one*) **Yes / No**
If yes, please list the mediation and the purpose:

Medication	***Purpose***
____________	____________
____________	____________
____________	____________
____________	____________

PHYSICAL TEST RESULT (*Physician must answer the two questions below and sign*)

1. Is the adoption applicant's state of health suitable for raising a child? (*Circle One*) **Yes / No**

If NO, please explain ____

____

____

2. Are there any ***unfavorable*** physical, mental, or psychological elements of the adoption applicant, which will affect the upbringing of the child? (*Circle one*) **Yes / No**

If YES, please explain ____

____

____

____________	____________	____________	____________
(Print Physician's name)	Physician's signature	License No.	Date