ADOPTIVE FAMILY HEALTH EXAM

This client has come to you in response to a request for a complete report on his/her physical condition or their minor child's physical health condition. This is for the purposes of completing a home study for adoption and needs to address any health factors which may interfere with this person's ability to raise a child from infancy to adulthood.

Name:	Date of Exam:
Address:	Date of Birth:

Current measurements/evaluation

Height:	Vision:	Blood pressure:
Pulse:	Lungs:	Heart:
Weight: If the patient is overweight, is he/she at a health risk?		
Is the patient on a weight reduction program? If so, what is the goal?		

Medical history of patient and current status (Check and give dates when possible.)

Accidents:	Diabetes:	Mental Illness:
Allergies:	Epilepsy/Seizure dis:	Neurological dis:
Anemia:	Hearing/Eye disorder:	Rheumatic Fever:
Asthma:	Heart problems:	
Cancer:	Hepatitis:	
List surgeries and dates:		
Other medical conditions:		
Comments on prognosis for continued health:		
Is patient currently on medication? Name and dosage:		
History of alcohol or drug abuse: Has patient ever participated in a drug or alcohol rehabilitation program?		
Adult patient: Is there evidence of physical or mental illness that would conflict with this person's ability to care for the health, safety or welfare of children? **If yes, please explain:** **Is the life expectancy within normal limits? If no, please explain.**		
Minor patient: In your opinion, does this patient have a physical, emotional or behavioral health problem that would impact the safety and welfare of an adopted child? **If yes, please explain:**		
How long have you known this patient?		

I have examined this patient and in my opinion, he/she is free of any communicable and contagious disease or any physical or mental impairment that could endanger an adoptive child placed in the same household in which this patient resides. Additionally, in my opinion, the patient does not have any physical or mental condition which would impair his/her ability to care for an adoptive child.

Physician's name:_____Telephone#_____

Address: _____

Examining physician's signature: _____