MEDICAL REPORT

To examining physician:
Our client is completing a home study for the purpose of adoption. Our agency is requesting a complete report on his/her physical condition. It is important for us to know of any health factors which may affect this person's ability to raise a child to adulthood.

Name _____ DOB _____
Date of examination _____ Name of physician _____
Height _____ Weight _____ Vision _____
Lungs _____ Blood pressure _____ Heart _____

Results of physical examination _____
_____
_____
Is this person free from communicable disease? _____
If this person is not free from communicable disease, is their condition well managed? _____

Conditions being treated	Treatments/medications
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medical history of patient: (Check and give dates when possible)

Asthma _____
Allergies _____
Epilepsy _____
Hepatitis _____
Meningitis _____
Tuberculosis _____
Mental illness _____
Heart problems _____
Accidents _____

Ear disorders _____
Tendency to colds _____
Pneumonia _____
Rheumatic fever _____
Diabetes _____
Ulcers _____
Cancer _____
Other medical conditions _____
_____

Operations:	Dates:
_____	_____
_____	_____
_____	_____

Comments on prognosis for continued health _____
_____
_____
_____

Is there any evidence of other illnesses or disabilities that might limit this person's activity, or make it impossible for him/her to care for a child for a number of years?

_____
_____
_____
_____

Physician's signature _____
Physician's name printed _____
Address _____
Telephone _____
Date_____

PLEASE return this to the presenting patient or fax to JFS at (223)-244-70236 or via email at afc@jfsofhbg.org.