# 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)-244-7026 or via email at afc@jfsofhbg.org.