10 West 7th Street, Suite F, Eureka, CA 95501
PH: (707) 444-9909 / FAX: (707) 442-6672
www.adoption-horizons.org

MEDICAL EXAM REPORT

Prospective Adoptive Parent

(Patient to complete shaded areas)

I hereby authorize ______________________________ to release the medical information contained on this form to **Adoption Horizons** for the purpose of investigating the adoptive placement of a child.

______________________________ ______________________________

Patient's Name Patient's Signature Date

____

Address

( ) ______________________________

Phone Number

I. MEDICAL HISTORY

☐ **New Patient** ☐ **Regular Patient** **How Long? __________ (Years)**

Check if condition is present and provide comment:

☐ Cancer
☐ Diabetes
☐ Heart Disease
☐ Hypertension
☐ Lung Disease
☐ GI Disorders
☐ Orthopedic Defects
☐ Arthritis
☐ Epilepsy
☐ Impaired Hearing, Sight, or Speech
☐ Other Neurological Disorders
☐ Tuberculosis
☐ Sexually Transmitted Disease
☐ Allergies
☐ Hereditary Disease or Abnormality
☐ Mental Health Issues
☐ Other Medical Condition
☐ Past Surgical Operations

Comments: ______________________________

1. Would any of these conditions prevent this patient from parenting a child or children? .... ☐ Yes ☐ No
2. Would any of these conditions significantly limit the patient's life expectancy? .... ☐ Yes ☐ No

II. PHYSICAL EXAMINATION

Height ____ ft ____ in Weight ________ Blood Pressure ________/________mm Hg

Eyes ______________________________

Ear, Nose, Throat ______________________________

Lungs ______________________________

Heart ______________________________

Abdomen ______________________________

Based on your knowledge and observations of the patient, how would you assess his/her physical health?

☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

III. TESTS / FINDINGS

Test	Date	Result	Other Findings
Urinalysis		☐ Normal ☐ Abnormal	
Tuberculosis		☐ Negative ☐ Positive	
BCG		☐ Yes ☐ No	
Chest X-Ray		☐ Normal ☐ Abnormal	

Was this patient screened with a chest x-ray only? ☐ Yes ☐ No

****Please attach a copy of the TB test findings to this report.****

IV. GENERAL HEALTH AND PHYSICAL CONDITION

What medications is the patient currently taking? (Use a separate sheet of paper if necessary)

Name	Dose	How Often	Reason for Taking

V. CHEMICAL DEPENDENCY

To your knowledge:

1. Has this patient had chemical dependency issues in the past? ☐ Yes ☐ No
2. Are there concerns about current chemical dependency? ☐ Yes ☐ No

Comments:

___

___

- Based on your knowledge and observations of the patient, how would you assess his/her mental/emotional health?

  ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Please use this space for any additional comments: ___

___

VI. INFERTILITY

1. Has the applicant been under treatment for infertility? ☐ Yes ☐ No
2. If infertility exists, has the medical basis been determined?
   If yes, please explain: ___
3. Is impregnation possible? ☐ Yes ☐ No
4. Which treatment, if any, would be effective? ___

VII. HIV TESTING (optional)

Optional HIV Test and Disclosure Authorization

The HIV test and authorization to disclose the results of the test are optional and intended only for patients who wish to submit to, or have undergone, a blood test for antibodies to the probative causative agent of acquired immune deficiency syndrome (AIDS) and choose to have their health care provider disclose the results of the test is accordance with Health and Safety Code Section 199.21 (g).

I hereby authorize Dr. ___ to release results of an HIV test to (1) Adoption Horizons for the purpose of investigating the adoptive placement of a child.

___ Patient's Name

___ Patient's Signature Date

HIV TEST RESULTS ☐ Positive ☐ Negative ☐ Indeterminate Date ___

☐ HIV TEST WAS DECLINED

VII. CERTIFICATE OF EXAMINATION

☐ **I certify that I have examined the above patient who was found to be free of communicable tuberculosis, chemical dependency, and is not suffering from any disease, disorder or mental condition that would prevent them from providing proper care for a child. I am not aware of any other contraindications to the fitness of this person to have a child placed in their home for the purpose of adoption.**

☐ **I cannot sign the above certificate for the following reasons:**

SIGNATURE OF DOCTOR	DATE EXAMINED
PRINTED NAME OF DOCTOR	MEDICAL LICENSE #
ADDRESS & PHONE NUMBER	OFFICE STAMP