Families through ADOPTION

Adult Name: _____

Creating a legacy of thriving families from the adoption plan to child's independence

ADULT MEDICAL

A. Please check (√) the following items:

Medical Problem	Now	Past	Never
AIDS or ARC			
Allergies			
Anemia/Sickle Cell			
Arthritis			
Asthma/Breathing Problems			
Blackout, Seizures, or Fainting			
Bleeds Easily			
Bowel Problems			
Broken Bones			
Cancer or Tumors			
Chest Pain			
Chills			
Choking			
Colds/Sore Throat/Flu			
Cough up/vomiting blood			
Delirium			
Dental Problems			
Diabetes/Hypoglycemia			
Difficulty swallowing/eating			
Eating Problems			
Eye/Vision Problems			
Headaches/Migraines			
Head Injury			
Hearing Impaired			
Heart Disease/Attack			
Hepatitis			
Hernia			
High Blood Pressure			
High Fevers			
HIV Positive			
IV Drug Use			

Medical Problem	Now	Past	Never
Kidney/Bladder Problems			
Liver Problems			
Lung Disease – COPD			
Menstrual Problems			
Muscular Weakness			
Nausea/vomiting			
Neurological Disease			
Night Sweats			
Rheumatic Fever			
Seizures			
Severe or Chronic Pain			
Sexual Problems			
Sexually Transmitted Disease			
Sinus Infections			
Skin Problems			
Sleep Problems			
Speech Impairment			
Stroke			
Surgeries			
Swollen Ankles/feet			
Trembling			
Thyroid Problems			
Tuberculosis			
Unplanned Weight Gain			
Unplanned Weight Loss			
Urinary Incontinence/weak bladder			
Urinary Tract Infections			
Other			

Comments: _____

Are you currently taking any prescribed medication? ☐ Yes ☐ No

Name of Medication	Dosage	When taken	For What	Prescribed By:	Effective?	
					Yes	No

Do you currently have, or have you ever had, medication allergies or an adverse reaction? ☐ No ☐ Yes

If yes, which medication: _____

HEIGHT: _____ WEIGHT: _____ AGE: _____

THIS SECTION TO BE COMPLETED BY THE PHYSICIAN

PHYSICAL LIMITATIONS OR RESTRICTIONS:

☐ None
☐ Describe: _____

PHYSICAL HEALTH CONCERNS, DIAGNOSES, OR FINDINGS:

_____

_____

_____

_____

_____

MENTAL HEALTH CONCERNS, DIAGNOSES, OR FINDINGS:

If the adoptive parent has a mental health diagnosis or is under medical care for a mental health diagnosis, is this treatment regimen effective? If a mental health intervention is recommended or was completed indicate by whom and when:

_____

_____

_____

_____

_____

PHYSICIAN'S FINDINGS:

☐ No physical or mental condition(s) that would interfere with the ability to parent
☐ Parenting may be limited by _____

Free of communicable diseases ☐ Yes ☐ No If no, which one(s): _____

PHYSICIAN'S RECOMMENDATIONS:

☐ Capable of adoptive parenting
☐ Medically and/or physically unsuited to parent

PHYSICIANS NAME (PRINT): _____ **LICENSE NUMBER:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

PATIENT SIGNATURE: _____ **DATE:** _____