ADOPTION CENTER FOR FAMILY BUILDING
8707 Skokie Blvd., Suite 208
Skokie, IL 60077
Office (847) 674-3231 Fax (847) 674-8635

MEDICAL REPORT

NAME OF PATIENT _____

DATE OF BIRTH _____
PURPOSE OF EXAMINATION: **ADOPTION**

HISTORY

1. Describe ALL of patient's medical conditions:_____

   _____

   _____

2. Are there any indications of emotional instability, depression, anxiety, alcoholism or any mental disorder? Yes No
   If yes, explain _____

   _____

3. Have any physical or psychiatric conditions been corrected, cured or controlled? Yes No
   If yes, explain: _____

   _____

4. Are there any conditions that are progressive in nature? Yes No
   If yes, explain: _____

5. Is there an illness that could interfere with this person's ability to care for a child in the next _____5 years, _____10 years, _____15 years? Yes No
   If yes, explain: _____

6. Please list any illness, injuries, operations or hospitalizations during the last five years?_____

   _____

MEDICATIONS

7. Please **list** all medications, dosage and for what purpose _____

   _____

   _____

8. Are there any physical limitations as a result of the medication(s)? Yes No
   If yes, explain: _____

HEALTH HABITS

9. Is there a history of substances used by this applicant and what degree of impairment exists, if any from the substance use?

Alcohol _____ Drugs _____
Tobacco _____ Other _____

PHYSICAL EXAMINATION

Weight _____ Height_____ Temperature _____

Pulse _____ Blood Pressure _____

Skin _____ Eyes _____ Ears _____

Nose/Throat _____ Teeth and Gums _____

Neck: Glands _____ Thyroid _____

Chest: Lungs _____Breasts _____

General _____

Abdomen: _____

Rectum _____ Pelvis _____
(If indicated) (If indicated)

SUMMARY OF FINDINGS _____

LABORATORY TESTS

(Must have been done within 6 months prior to submitting this report.)

	DATE PERFORMED	RESULTS
Urinalysis	_____	_____
Tuberculin Test*	_____	_____

*If positive, date and results of applicant's chest X-ray _____

I CERTIFY THAT THIS INDIVIDUAL IS FREE FROM SYMPTOMS OF COMMUNICABLE DISEASE.
YES NO IF NO, EXPLAIN: _____

I CERTIFY THAT THIS INDIVIDUAL HAS NO PHYSICAL, COGNITIVE OR EMOTIONAL LIMITATIONS THAT IMPAIR HIS/HER ABILITY TO EFFECTIVELY PARENT AN INFANT OR CHILD OR THAT IMPAIR HIS/HER ABILITY TO EFFECTIVELY PARENT A CHILD THROUGH ADOPTION.
YES NO IF NO, EXPLAIN: _____

If required for the adoption assessment, an additional letter <u>may</u> be requested to clarify a medical condition.

SIGNATURE OF EXAMINING PHYSICIAN

_____

DATE OF EXAMINATION _____

State License Number _____

PRINT OR STAMP DOCTOR'S NAME AND ADDRESS

NAME: _____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____