

Adopt!inc.
135 Lackawanna Road
Lexington, KY 40503

Phone: 859-276-6249
Fax: 859-276-5570
Web Site: www.adoptinc.org
E-Mail: adopt@adoptinc.org

MEDICAL EXAMINATION

Name: _____ Date of Birth: _____

Address: _____

MEDICAL HISTORY

(check if applicable)

- Tuberculosis _____
- Allergies _____
- Impaired Hearing _____
- Venereal Disease _____
- Impaired Vision _____
- Mental Illness _____
- Stillbirths/Miscarriage _____
- Epilepsy _____
- Cancer _____
- Diabetes _____
- Infertility _____
- Surgical Procedures _____
- Serious Illness _____
- Emotional Difficulties _____

Please elaborate: _____

Date of Exam _____ How long have you known the patient? _____

Height _____ Weight _____ Extremities _____ Eyes _____ Heart _____
Ears/Nose/Throat _____ Genitourinary tract _____ Abdomen _____ Lungs _____

This household member is free of any illness or condition that presents a health or safety risk to a child placed in the home. Yes _____ No _____

Results of any laboratory or other tests you feel are necessary: _____

List any regularly prescribed medication(s): _____

For adults: It is my opinion that this adult is physically and mentally able to parent a child. Yes _____ No _____

Additional comments: _____

If you would like to speak to the adoption worker, check here. _____

Signature of Physician _____ Date _____

Printed name and address of physician
Name _____

Address _____