



GENERAL PHYSICAL EXAMINATION FOR ADOPTIVE APPLICANT

A NOTE TO THE EXAMINING PHYSICIAN:

Please print clearly or type all information. Do not leave any question blank. Incomplete or illegible forms will need to be re-done. NO WHITE OUT PLEASE!

Applicant's Name: _____ DOB: _____

Address: _____

MEDICAL HISTORY—Please check “No” or “Yes” and indicate Type:

	NO	YES	TYPE		NO	YES	TYPE
Tuberculosis	_____	_____	_____	Tumors	_____	_____	_____
Heart Disease	_____	_____	_____	(if “yes” please specify benign or malignant tumor)	_____	_____	_____
Sexual Disease	_____	_____	_____	Liver Disease	_____	_____	_____
Mental Illness	_____	_____	_____	Nervous Disorder	_____	_____	_____
Lupus	_____	_____	_____	Epilepsy	_____	_____	_____
Any Operations	_____	_____	_____	Genetic Disease	_____	_____	_____
(date & reason)	_____	_____	_____	Alcohol/Drug Abuse	_____	_____	_____
	_____	_____	_____	Other Communicable Diseases	_____	_____	_____

PHYSICAL EXAMINATION –Please check, fill-in, or circle one of the following:

Date of Exam: _____ Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
Right Eye	_____	_____	Liver	_____	_____
Left Eye	_____	_____	Lungs	_____	_____
Right Hearing	_____	_____	Lymph	_____	_____
Left Hearing	_____	_____	Thyroid	_____	_____
Heart	_____	_____	Nervous System	_____	_____
Kidneys	_____	_____	Liver Function	_____	_____

HBsAntigen: Date: _____ Results: *Neg.* or *Pos* (**circle one**)

HIV Test: Date: _____ Results: *Neg.* or *Pos.* (**circle one**)

Blood Count: Date: _____ Hb: _____ Hct: _____ WBC: _____

Urinalysis: Date: _____ S.G: _____ Alb: _____ Sug: _____

MEDICATIONS—Please indicate the following:

Is the patient taking any medications? **(please circle)** *Yes* or *No*

If yes, name of medication(s) and dosage amount: _____

Purpose of medication(s) _____

Has the treatment been successful? _____

PHYSICIAN'S STATEMENT:

It is my opinion that the applicant is in good and stable physical and mental condition necessary to provide responsible care for an adopted child.

Signed: _____, *M.D. / D.O* (**circle**) **Date:** _____

Doctor's Printed Name: _____ License No. _____

APPLICANT'S PERMISSION FOR RELEASING INFORMATION: I, _____ (your signature), hereby give permission for release of complete information about my physical and mental condition to CCAI.