

MEDICAL REPORT-Adoptive Parent

Patient's name _____ DOB _____ Age _____

Address _____

Date of examination _____

Lenth of time known to physician _____

Has the patient had any diseases such as: allergies; diabetes; tuberculosis; cancer; heart disease; epilepsy; ulcers; or sickle cell anemia? _____

Please explain treatment and prognosis _____

Other medical history, such as surgery, traumas, or hospitalizations _____

Has the patient ever had a chemical dependency? _____ If so, for how long? _____

Please explain _____

Mental health history, such as emotional problems, depression, or nervous disorders

Is the patient physically capable of having children? _____ If not, why not? _____

Treatment given _____

Further treatment recommended _____

Please describe any physical limitations such as glasses, hearing impairment, or dialysis

Please describe the findings of your examination of the patient _____

Has your examination revealed any threat to the patient's general health and life expectancy?

What are your impressions of the patient's physical and emotional qualifications for parenthood? _____

Date of Examination _____

Printed name of Physician

Signature of Physician

Address

Physician's specialty

City

State

Zip

Telephone

Please mail this report to:

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