Medical Report on Prospective Adoptive Parent

Name of Applicant: _____

Date of Exam (day/month/year): _____

How long have you known this patient? _____

How often have you seen this person in the last year? ☐ None ☐ Once ☐ 2-10 times ☐ 11-25 times ☐ 26+ times

Patient's height: _____ Patient's weight: _____

Diagnosis (Please check all that apply)

Neurological Disorders
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Parkinson's disease
- ☐ Cerebrovascular disease *(Stroke, Cerebral Aneurysm)*
- ☐ Brain Injury
- ☐ Learning disability (Dyslexia, Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Dementia
- ☐ Migraine
- ☐ Other neurological disorders

Multi-System Disorders
- ☐ Cancer-Malignant Disease
- ☐ AIDS (includes HIV)
- ☐ Lupus
- ☐ Other multi-system disorders

Cardiovascular
- ☐ Cardiovascular disease *(Heart disease, Heart attack, Pulmonary Embolism)*

Respiratory Disorders
- ☐ Asthma
- ☐ Allergies
- ☐ Tuberculosis
- ☐ Other

Muscular-Skeletal Disorders
- ☐ Arthritis *(Osteoarthritis, Rheumatoid arthritis)*
- ☐ Fibromyalgia/Chronic Fatigue Syndrome
- ☐ Degenerative Disc Disease
- ☐ Low back pain syndrome disorder
- ☐ Spinal Stenosis
- ☐ Other muscular skeletal disorders

Gastrointestinal Disorders
- ☐ Crohn's disease
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Ulcers
- ☐ Liver disease (Cirrhosis, Hepatitis)
- ☐ Other gastrointestinal disorders

Renal Disorders
- ☐ Kidney disease
- ☐ Chronic renal failure

Endocrinology Disorders
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Obesity
- ☐ Other endocrinology diseases

Addictions
- ☐ Alcohol
- ☐ Drugs

Mental Health
- ☐ Psychotic/Schizophrenia
- ☐ Affective Disorder *(Depression, Bipolar, Mania)*
- ☐ Anxiety/Panic Attacks
- ☐ Eating disorder
- ☐ Personality disorder
- ☐ Post-Traumatic Stress Disorder (PTSD)
- ☐ Other:

Sensory Disorders
- ☐ Blindness
- ☐ Visual impairment
- ☐ Deafness
- ☐ Hearing impairment
- ☐ Other sensory. Please specify

Other Disorders
- ☐ Fertility treatment
- ☐ Chronic disorder
- ☐ Organ transplant
- ☐ STD
- ☐ Sickle Cell Anemia
- ☐ Intellectual disability
- ☐ Other physical

Sleep Disorders
- ☐ Apnea
- ☐ Insomnia
- ☐ Other

For any checked diagnosis from above please provide more specific details of presenting symptoms, date of onset, prognosis, treatments, *including medications, dosage etc.,*

_____

_____

_____

Do any of these medical conditions impact the applicant's ability to be an effective parent? (eg. bending or lifting) or prevent the applicant from handling the additional demands created by adopting children (emotional stability)?

Specify: _____

_____

Reason for Infertility (if applicable): _____

_____ _____

Name of physician (please print) Signature of physician

_____ _____

Address of physician Phone