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ADULT MEDICAL STATEMENT

Patient's Name: _____ DOB: _____

Date of Exam: _____

List any significant medical history: _____
_____
_____
_____
_____

Physical Exam
Height: _____ Weight: _____ Blood Pressure: _____
Ears/Nose/Throat: _____ Heart: _____ Lungs: _____

List any prescribed medications: _____
_____
_____

Is there any organic or functional disorder that would affect the patient's life experience of ability to function as a parent? _____ If yes, please elaborate: _____
_____
_____

How long have you known the patient? _____
From a medical perspective, would you recommend this patient as an adoptive parent? _____

Additional Comments/Concerns: _____
_____
_____
_____

Licensed Medical Practitioner's Signature: _____
Type/Print Name of Licensed Medical Practitioner: _____
Address of Licensed Medical Practitioner: _____
Telephone: _____