

Medical Information for Adoptive Parents

Applicant Name: _____ Date of Birth: _____

Address: _____

Date of Exam: _____ Height: _____ Weight: _____

Blood Pressure: _____ Pulse: _____

Any abnormalities of the following:

Heart: _____ Vision: _____

Lungs: _____ Hearing: _____

Nervous System: _____ Speech: _____

Gastrointestinal: _____ Musculoskeletal: _____

Genitourinary: _____

Any current disabilities and/or chronic disease: _____

History of surgery and/or hospitalizations: _____

Information regarding infertility, including tests and medical intervention:

History of communicative disease, if any: _____

Other illnesses: _____

History of emotional difficulties and/or alcohol/drug use: _____

Have there been miscarriages, stillbirths or infant deaths in the family:

TEST RESULTS:

Time: _____

Scrology (VDRL): _____

Hepatitis B: _____

Please comment on capability of the applicant to reach normal life expectancy: _____

Physician Name (please print): _____

Address: _____

Telephone: _____

Date: _____

Signature: _____

**Please return to: Community Care Services
Adoption Program
70 Main Street
Taunton, MA 02780**