

# AAI ADOPTIVE PARENT MEDICAL FORM

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PLEASE COMPLETE THE TOP PORTION OF THIS FORM AND BRING TO YOUR MEDICAL APPOINTMENT.**

**APPLICANT:** Have you ever had any of the following conditions? If yes, please provide an explanation below. If you have or have had in the past, a mental health diagnosis such as depression or anxiety you must provide a letter from your therapist or psychiatrist regarding whether this diagnosis will impact your ability to care for an adoptive child.

MEDICAL HISTORY	
Tuberculosis?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tumor?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Heart Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Liver Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Sexual Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Neuropathy?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Mental Health Diagnosis and/or treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Other Communicable Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Alcoholism or Substance Abuse?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any Genetic Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Any Surgical Operations?	<input type="checkbox"/> YES <input type="checkbox"/> NO

**Explanation:** \_\_\_\_\_

**EXAMINING PHYSICIAN:** The person named above has applied to become an adoptive parent. The Virginia Dept. of Social Services requires a recent medical examination to assess the applicant's mental and physical health. If the applicant has any of the health conditions noted above or any other significant health issue, please provide a letter of explanation to clarify the issue. Feel free to contact us if you have any questions. Thank you for your cooperation.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

## PLEASE ANSWER THE FOLLOWING QUESTIONS

- 1) Is the applicant taking any medications?  YES  NO (If yes, please list them & what they are for)  
\_\_\_\_\_
- 2) Does the applicant have a medical, psychological or otherwise unfavorable health condition, which would impact his/her ability to care for an adoptive child?  YES  NO (If Yes, please explain)  
\_\_\_\_\_
- 3) Is the applicant's state of health suitable for raising a child?  YES  NO (If No, please explain)  
\_\_\_\_\_
- 4) Is the applicant free from communicable disease?  YES  NO (If No, please explain)  
\_\_\_\_\_
- 5) Is the applicant in good general health with normal life expectancy?  YES  NO (If No, please explain)  
\_\_\_\_\_

Signature of MD: \_\_\_\_\_ Date: \_\_\_\_\_  
Name of Physician (printed): \_\_\_\_\_  
Clinic Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Please mail/fax/scan this medical form to:  
Autumn Adoptions, Inc.  
P.O. Box 1204 Lorton, Virginia 22199-1204  
TEL 703.646.3458 FAX 703.485.1293 EMAIL [autumnadoptions@msn.com](mailto:autumnadoptions@msn.com)