

# 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 703.568.1314 FAX 703.485.1293 EMAIL [autumnadoptions@msn.com](mailto:autumnadoptions@msn.com)