Society Office Complex
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Claymont, DE 19703

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Madison Adoption Associates

MEDICAL EXAM - ADULT

TO EXAMINING PHYSICIAN: Your medical report is of paramount importance to the adoption authorities in their examination of the adoption qualification of the adopters. Thank you for your cooperation.

Applicant's Name:_____ DOB: _____

Address: _____

MEDICAL HISTORY:

Have you ever had Tuberculosis?	No / Yes	Tumors?	No / Yes
Heart disease?	No / Yes	Liver disease?	No / Yes
Sexual disease?	No / Yes	Neuropathy?	No / Yes
Mental disease?	No / Yes	Other communicable disease?	No / Yes
Alcoholism/Substance abuse history?	No / Yes	Any genetic disease?	No / Yes
Any surgical operations?	No / Yes		

If yes to any, please explain: _____

_____

PHYSICAL EXAMINATION:

Height:_____inches Weight:_____pounds Blood pressure: _____

Vision: L _____ R _____ Hearing: L: Normal / Abnormal R: Normal / Abnormal

Heart:	Normal / Abnormal	Liver:	Normal / Abnormal
Lungs:	Normal / Abnormal	Lymph:	Normal / Abnormal
Thyroid:	Normal / Abnormal	Nerve system:	Normal / Abnormal
HbsAg:	Negative / Positive	Routine Blood Test:	Normal / Abnormal
Blood test (Date of Test): _____		Liver Function:	Normal / Abnormal
Urinalysis (Date of Test): _____		Routine Urine Test:	Normal / Abnormal
HIV Test (Date of Test): _____		HIV Test:	Negative / Positive
[Colombia Only] PPD (Date of Test): _____		PPD Test:	Negative / Positive

Is the patient taking any medication? _____

For what purpose: _____

PHYSICAL TEST RESULT:

1) Are there any physical, mental, or psychological unfavorable elements of the adoption applicant, which will affect the upbringing of the child? Yes / No

2) Does the adoption applicant have any disability that would affect the applicant's ability to case for a child? Yes / No

3) Is the adoption applicant's state of health suitable for raising a child? Yes / No

Physician's Signature: _____ Date: _____

Physician's name (print clearly): _____ License No. _____

Subscribed and sworn to before me this _____ day of _____, 20____ by

_____ *who is:*

☐ *personally known to me OR* ☐ *produced their* _____ *as identification.*

_____ _____ _____

Notary Public *State* *County*

_____

My Commission Expires