REPORT OF HEALTH EXAMINATION
CATHOLIC CHARITIES OF NOTHERN KANSAS

NAME: _____

ADDRESS: _____

PHONE: _____

I. Medical History:
Please check the following:

SELF:	YES:	**FAMILY HISTORY:**	YES:	IF YES, WHOM:
Cardiovascular Disease	_____	Cardiovascular Disease	_____	_____
Nephritis	_____	Nephritis	_____	_____
Tuberculosis	_____	Tuberculosis	_____	_____
Venereal Disease	_____	Venereal Disease	_____	_____
Cancer	_____	Cancer	_____	_____
Epilepsy	_____	Epilepsy	_____	_____
Mental Illness	_____	Mental Illness	_____	_____
Handicapping Condition	_____	Handicapping Condition	_____	_____
Major Surgery	_____	Major Surgery	_____	_____
Other	_____	Other	_____	_____

II. What were the significant findings of your physical examination?

General Appearance
Skin
Heart
Lungs
Abdomen
Extremities
Mouth & Pharynx
Eyes
Ears
Muscular System
Reflexes
Blood Pressure
Height
Weight (state if patient is obese)

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III. What were the results of these specific laboratory tests or procedures?

a. Tuberculin test and/or chest X-Ray _____ _____
(pos or neg) (date)

b. Urinalysis _____ _____
(pos or neg) (date)

In your opinion, are further laboratory tests required and, if so, which ones?

IV. Does you examination indicate that the patient has any physical or mental condition which might unfavorably affect an adoptive child? If so, please explain.

V. Does the patient have a life expectancy within average limits?

VI. Have you reason to believe this patient is infertile or relatively infertile? Explain.

VII. Would you advise referring this patient to an infertility clinic for further consultation? If not, why?

VIII. For how long a period of time has this individual received medical care and supervision from you?

Signature of Provider _____

Provider Name (printed) _____

Address of Practice _____

Date _____