I. Medical History:
Please check the following:

<table>
<thead>
<tr>
<th>SELF:</th>
<th>YES:</th>
<th>FAMILY HISTORY:</th>
<th>YES:</th>
<th>IF YES, WHOM:</th>
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<tr>
<td>Cardiovascular Disease</td>
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<td>Tuberculosis</td>
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<td>Handicapping Condition</td>
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<td>Major Surgery</td>
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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)
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 your 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