

**PHYSICIAN REPORT ON  
ADOPTIVE APPLICANTS**

Name \_\_\_\_\_ Date of Exam \_\_\_\_\_

How long has patient been under your care? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Temperature \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Urinalysis (Specify Diagnosis, if not within normal limits) \_\_\_\_\_

\_\_\_\_\_

History of Previous Illness and/or surgery \_\_\_\_\_

\_\_\_\_\_

Physical Findings (Check if Normal. Describe any abnormal findings below)

Eyes \_\_\_\_\_ Circulatory \_\_\_\_\_ Genito-Urinary \_\_\_\_\_

Ears \_\_\_\_\_ Heart \_\_\_\_\_ Gynecological \_\_\_\_\_

Nose \_\_\_\_\_ Lungs \_\_\_\_\_ Neurological \_\_\_\_\_

Throat \_\_\_\_\_ Abdomen \_\_\_\_\_ Other \_\_\_\_\_

Mouth \_\_\_\_\_ Extremities \_\_\_\_\_

Describe here abnormalities noted above \_\_\_\_\_

\_\_\_\_\_

Characteristics of disability \_\_\_\_\_

\_\_\_\_\_

Stable \_\_\_\_\_ Progressive \_\_\_\_\_ Improving \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Name (print)

\_\_\_\_\_  
Address/Phone No.