PHYSICIAN'S REPORT

Please mail directly to:

Adoption Counseling Services, Inc.
2185 Wickersham Lane
Germantown, Tennessee 38139

Patient:______________________________ has been known to me professionally for _______ years. On the _______ day of ______________________, 20___, I examined him/her and I submit the results as follows:

PHYSICAL FINDINGS:

General appearance:____
Weight:______________ Height:_________________ Blood Pressure:________________________
Pulse:________________ Temperature:_______________________

Check those which are abnormal and describe below:

Scalp _____	Sight _________	Hearing ___________	Teeth _______________
Neck __________	Tonsils________	Thyroid ___________	Heart _______________
Lungs__________	Skin _________	Spine ___________	Mouth _______________
Abdomen________	Extremities_____	Kidneys ___________	Lymph Glands_________

Comments:____

LABORATORY FINDINGS: (All tests must be within the last year)

Urinalysis___________ Date_____________ Results____
VDRL______________ Date_____________ Results____
T.B.Test (if positive, given results of chest x-ray)
Date_____________ Results____
H.I.V.____________ Date_____________ Results____
Does patient take prescription drugs on a regular basis?____________
If yes, please explain:____

Does this patient have any medical or congenital conditions, diseases or syndromes?______________
If yes, please list:____

How will this affect the patient's quality of life and life span?___________________________________

Is there a past history or present history of chemical dependency (Drug or Alcohol)_________________
Nervous Disorder______ Previous Surgery__________ Cancer_______ Diabetes_____ Venereal Disease____________

Does this patient or any member of his/her family have a history of mental illness or emotional problems?

If you answered yes to any of the aforementioned, please explain fully below (i.e., dates, treatment, current prognosis, etc.)

What is the cause of childlessness?____

For how long?____

Does this patient have any medical or emotional condition that would impair his/her ability to adopt, raise and care for a child?____

In your opinion, can this person physically, emotionally and mentally parent an adopted child?________

Printed Name:______________________________
Address: ______________________________
____
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Signed: ______________________________