DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

Adoptive Parent Health Report

Use of form: Use of this form is required and meets the requirement of DCF 50.05(6)(h). Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: Each adoptive parent shall present this form to the physician, physician's assistant or Health Check provider to be filled out and signed upon completion of the required health examination. The agency shall file the completed health report in the adoptive family record.

Name – Applicant		Return To:
Name – Physician	Telephone No. – Physician	
Name – Clinic		
Address – Clinic (Street, City, State, Zip)		
Date of Examination		

1. How long has the above applicant been your patient? _____

2. Does patient have any personal or familial history of:

Yes	No	Unk	
☐	☐	☐	Accidents (auto, etc.)
☐	☐	☐	Diabetes
☐	☐	☐	Ulcer
☐	☐	☐	Mental illness
☐	☐	☐	Sexually transmitted disease
☐	☐	☐	Lung disease (TB, Emphysema)
☐	☐	☐	Psychiatric disorder
☐	☐	☐	Cancer
☐	☐	☐	Surgery
☐	☐	☐	Serious injuries
☐	☐	☐	Endocrine disorder
☐	☐	☐	Renal disorder
☐	☐	☐	Neurologic disorder
☐	☐	☐	Cardio Vascular disease

3. Other significant medical history:

4. Weight: _____

5. Height: _____

6. Blood pressure: _____

7. Does patient have any personal or familial history of:

Yes	No	Unk		Yes	No	Unk	
☐	☐	☐	Eyes	☐	☐	☐	Skin
☐	☐	☐	Ears	☐	☐	☐	Liver
☐	☐	☐	Nose	☐	☐	☐	Kidneys
☐	☐	☐	Throat	☐	☐	☐	Lymph glands
☐	☐	☐	Mouth, teeth, gums	☐	☐	☐	Abdomen
☐	☐	☐	Bones and joints	☐	☐	☐	Genitalia
☐	☐	☐	Lungs	☐	☐	☐	Rectum
☐	☐	☐	Heart	☐	☐	☐	Reflexes
☐	☐	☐	Spleen	☐	☐	☐	Other

8. Other significant physical findings:

9. Laboratory findings including any evidence of communicable disease:

a. TB test or chest X-Ray results: _____ Date of test / X-Ray: _____

b. Other significant lab results (urine and blood test, etc.)

10. Medications - Please attach a list of current medications and specify what each medication is used to treat

11. Does the adult have any personal habits that might effect or impact health condition:

Yes	No	Unk		Specify Amount
☐	☐	☐	Smoking	_____
☐	☐	☐	Drinking alcoholic beverages	_____
☐	☐	☐	Use of other drugs	
☐	☐	☐	Lack of exercise	
☐	☐	☐	Hazardous work environment	
☐	☐	☐	Overweight	_____

12. What changes have you recommended to the patient?

13. ☐ Yes ☐ No Based on your knowledge of the patient and your findings of the examination, is there anything you think would adversely affect, or enhance his / her ability to provide care (parent) an adopted child? If "Yes", explain.

14. ☐ Yes ☐ No Based on your findings on this date, will the patient probably live to raise a child to age 18?

_____ _____

SIGNATURE – Physician Date Signed