MEDICAL STATEMENT

(to be completed by physician)

(Examination must not be made by a relative of the patient)

Patient's Name______________________________ Date of Birth ____________

Height	______________	Weight	______________
Pulse	______________	Blood Pressure	______________
Vision	______________	Hearing	______________
Heart	______________	Lungs	______________
Skin	______________	Orthopedic Defects	______________
Teeth	______________	Endocrine System	______________
Abdomen	______________	Nervous System	______________
Other	______________	Cancer	______________
Allergies	______________	Surgery	______________
Mental Illness	______________	Chronic Condition	______________

LABORATORY:	**Date**	**Results**
Tuberculin Test	__________	______________
Hepatitis B	__________	______________
HIV	__________	______________
Chest X-rays (required if tuberculin is positive)	__________	______________

Fertility Status ____
____

Length of time patient has received care from you and follow-up plan, if any________________
____

Is the patient in good health at the present time? ______________________

In your opinion does the patient have normal life expectancy? ______________________

Could you add anything related to the personality, physical condition or past health history, not already explained which would affect the patient's ability to take on responsibilities of parenthood?

____

Physicians signature Date

____

Address

____

City State Zip Code Phone

Note: If more space is needed, use reverse side