8487 Ridge Road, Cincinnati, Ohio 45236 513-489-1616 Fax 513-766-3338

MEDICAL HISTORY OF ADOPTIVE APPLICANTS

Name ____ Date _______________

Address ____

FAMILY HISTORY	AGE (IF LIVING)	STATE OF HEALTH If not 'good', give reasons	CAUSE OF DEATH & AGE AT THAT TIME
Father			
Mother			
Brothers			
Sisters			

Have you served with the Armed Forces?____

If yes, what years did you serve?____

Have you ever applied for or received disability compensation?__________________________

Do you have any chronic medical conditions? Please describe.__________________________
____
____

Do you have a communicable disease that would be detrimental to the health of an adoptive child? ____

Please list current medications that you are taking at this time.

____
____

Evaluate your current medical status____

____

Who is your current medical provider?

____

List all physicians whom you have consulted in the last 5 years.

Physician's name & address	Reason for Consultation	Date & Duration

Have you ever received mental health services or therapy? (Please include all psychiatrists, psychologists, social workers or other helping professions):

Name	Address	Phone	Date/ Duration of Treatment	Result

If you have received medical treatment for infertility issues, please list the medical professional who provided treatment and briefly describe treatment received. (Give name, address and phone)

____

____

Women please answer next set of questions.

Have you ever delivered any children? __________

If so, how many? ______________

Date of last delivery?_____________

I hereby give Adoption Connection permission to consult any of the above medical or counseling sources for information related to our adoption application or homestudy.

____
Signature of Applicant

____
Date