Adult Medical Report
(Must be completed by a Medical Doctor)

Patient Name: _____ DOB: _____

Date of Exam: _____ Weight: _____ Height: _____

Does this patient have any medical conditions that could interfere with their ability to parent a child to adulthood? YES NO

If yes, please explain:
_____
_____
_____

Does this patient have any mental health conditions that could interfere with their ability to parent a child to adulthood? YES NO

If yes, please explain:
_____
_____
_____

Is this patient free of any communicable diseases? YES NO

If no, please explain:
_____
_____
_____

Based on current medical knowledge, does this patient have a normal life expectancy? YES NO

If no, please explain:
_____
_____
_____

Doctor's Signature: _____
Doctor's Printed Name: _____
Office Address: _____
Office Telephone: _____ Office Fax: _____

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