Medical History Form

Each adult household member must complete a separate Medical History Form. Please answer all questions as completely and accurately as possible.

PLEASE NOTE: A statement from a medical professional or a completed physical examination will still be required. Depending on your medical history and the results of your physical, additional documentation or follow-up may also be requested.

The medical history portion of the home study can sometimes take the longest to complete, particularly if additional records or information are needed. We recommend scheduling your medical appointments as early as possible in the home study process to help avoid delays and ensure all required documentation is received in a timely manner.

Personal Information

Full Name: _____

Date of Birth: _____

Primary Care Physician: _____

Physician Phone: _____

Date of Last Physical Exam: _____

Medical Conditions

Have you ever been diagnosed with any of the following conditions? Check all that apply:

[ ] Heart disease [ ] Diabetes [ ] Asthma [ ] Cancer [ ] High blood pressure

[ ] Mental health diagnosis [ ] Chronic pain [ ] Neurological disorder

[ ] Other (please specify): _____

If any boxes are checked, please provide details including diagnosis, treatment, and current status:

_____

_____

_____

_____

_____

_____

_____

Current Medications

List all medications you are currently taking (prescription and over-the-counter):

Medication | Dosage | Reason for Use

_____

_____

_____

_____

Mental Health History

Have you ever received counseling or mental health treatment? [ ] Yes [ ] No

If yes, please explain (dates, provider, reason for treatment):

_____

_____

_____

_____

_____

_____

Substance Use

Do you currently use or have a history of using the following?

Tobacco: [ ] Yes [ ] No Alcohol: [ ] Yes [ ] No Recreational drugs: [ ] Yes [ ] No

If yes to any, please explain: _____

_____

_____

_____

_____

_____

_____

_____

_____

Functional Abilities

Do you have any physical or mental health conditions that limit your ability to care for a child?

[ ] Yes [ ] No

If yes, please describe: _____

_____

_____

_____

_____

Certification

I certify that the information provided on this form is accurate and complete to the best of my knowledge.

Signature: _____ Date: _____