

PATIENT MEDICAL INFORMATION -ADULT (In Applicant's Home)

TO THE EXAMINING PHYSICIAN	The applicant below is considering the placement of a child in their home. The Department of Social Services needs information on his/her physical and mental health, and the extent and significance of any health condition their ability to parent a foster/adoptive child.
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APPLICANT'S FULL NAME	DATE OF BIRTH	HOW LONG PHYSICIAN HAS KNOWN APPLICANT
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I. PHYSICAL EXAMINATION

Height	Weight	Temperature	Pulse	Blood Pressure	Respiration Rate	Vision	Hearing
Lungs				Heart			
Allergies:							
Nervous System			Endocrine			DATE OF ANNUAL INFLUENZA SHOT (MANDATORY)	

LIST CURRENT PRESCRIBED MEDICATIONS:

II. LABORATORY TESTS (list tests and results)

Test	Date	Result
Tuberculin Test		
Chest X-Ray		

III REASONS FOR CHILDLESSNESS, IF APPLICABLE (include prognosis, if known)

<p>IV. GENERAL HEALTH: (attach additional pages as needed) DOES THE PATIENT HAVE THE USUAL LIFE EXPECTANCY?</p> <hr/> <p>DOES THE PATIENT HAVE ANY CONTAGIOUS OR INFECTIOUS DISEASE?</p> <hr/> <p>DOES THE PATIENT HAVE A CHRONIC DISEASE OR EMOTIONAL CONDITION OR ANY DISABILITY THAT WILL AFFECT THE PARENTING OF A FOSTER OR ADOPTIVE CHILD?</p> <hr/> <p>WAS ANY RECOMMENDATION FOR MEDICAL OR MENTAL HEALTH CARE MADE TO THE PATIENT? (IF YES, EXPLAIN)</p>	<p>5. HAS THE PATIENT BEEN TREATED OR HOSPITALIZED FOR ANY OF THE FOLLOWING :(explain)</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> ANXIETY</td> <td><input type="checkbox"/> DRUG/SUBSTANCE ABUSE</td> </tr> <tr> <td><input type="checkbox"/> DEPRESSION</td> <td><input type="checkbox"/> BI-POLAR DISORDER</td> </tr> <tr> <td><input type="checkbox"/> SUICIDE ATTEMPTS</td> <td><input type="checkbox"/> PSYCHOSIS</td> </tr> <tr> <td><input type="checkbox"/> ALCOHOLISM</td> <td><input type="checkbox"/> OTHER (explain)</td> </tr> </table>	<input type="checkbox"/> ANXIETY	<input type="checkbox"/> DRUG/SUBSTANCE ABUSE	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> BI-POLAR DISORDER	<input type="checkbox"/> SUICIDE ATTEMPTS	<input type="checkbox"/> PSYCHOSIS	<input type="checkbox"/> ALCOHOLISM	<input type="checkbox"/> OTHER (explain)
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<input type="checkbox"/> ALCOHOLISM	<input type="checkbox"/> OTHER (explain)								

V. Would you recommend this patient as a Resource Parent? (If examiner knows patient personally as the family physician, any comment would be welcome):

PHYSICIANS SIGNATURE	DATE OF EXAM	RETURN COMPLETED FORM TO:	
PHYSICIANS NAME (Print or Type)			

Address (Include City, State, Zip Code)

TO BE COMPLETED BY APPLICANT

SIDE 1

State of Maryland- Resource Development and Placement

PATIENT MEDIAL INFORMATION ADULT

FULL NAME	BIRTHDATE
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BRIEFLY DESCRIBE AND GIVE APPROXIMATE DATES FOR THE FOLLOWING:

MAJOR ILLNESSES:

HOSPITALIZATIONS:

SURGERY:

ACCIDENTS:

PSYCHIATRIC/MENTAL HEALTH TREATMENT:

ALCOHOL/DRUG TREATMENT:

FAMILY MEDICAL HISTORY - IS THERE A HISTORY OF:

	YES	NO		YES	NO		YES	NO
ALLERGIES			ALCOHOL/DRUG USE			ANEMIA		
DIABETES			MENTAL ILLNESS/RETARDATION			OTHER (specify)		
HEART DISEASE			HYPERTENSION					
CANCER			LUNG DISEASE					

DESCRIBE YOUR GENERAL HEALTH CONDITION & LIST ANY CURRENT MEDICATIONS:

ARE YOU CURRENTLY RECEIVING ANY TREATMENT, THERAPY OR REHABILITATION FOR MEDICAL OR MENTAL HEALTH PROBLEMS?

YES NO (If yes, please provide name, address, and telephone number of provider)

DO YOU DRINK ALOCHOLIC BEVERAGES? YES NO (if yes, please describe)

DO YOU SMOKE? YES NO

HAVE YOU EVER USED ILLEGAL CONTROLLED DANGEROUS SUBSTANCES? YES NO

HAVE YOU EVER UNDEGONE FERTILITY TESTING? YES NO

PLEASE NOTE: ADDITIONAL INFORMATION MAY BE REQUESTED