Ohala' Adoptions

MEDICAL HISTORY REPORT

Note: This form is to be completed and certified by a physician. Please print legibly in black or blue ink.

Name:_____Date: _____
Last Name First M.I.

Gender:_____ Ht:_____ Wt:_____ Eye Color:_____ Body Mass Index:_____

Physician's Name:	Tel No:
Name and Address of Clinic:	

Personal History: Please check all medical conditions that apply.

	Medical Condition	Past Medical History	Current Medical Condition	For every medical condition checked, briefly describe. Use the back of paper if more space is needed.
1	Diabetes			
2	High Blood Pressure			
3	Cancer			
4	Tuberculosis			
5	Heart Disease			
6	Hepatitis			
7	Auto-Immune Disorder			
8	Depression			
9	Anxiety			
10	Kidney Disease			
11	Skin Disease			
12	Seizure Disorder			
13	Mental Illness			
14	Stomach/Intestinal Disorders			
15	Head Injuries			
16	Fractures			
17	Hearing Impairment			
18	Vision Impairment			
19	Thyroid Disease			
20	Lung disease			
21	Asthma			
22	Allergies			
23	Organ Transplant			
24	Stroke			
25	Pacemaker			

26	Degenerative Muscular Disorder			
27	Other(s):			

Please answer Yes or No on the questions below. If "Yes", provide your comment on the space provided.

	Yes	No	If yes, please specify the frequency and duration.
Currently taking medications(s)?			
Any history of/current tobacco use?			
Any history of/current alcohol use?			
Any history of/current drug abuse?			

PHYSICIAN'S CERTIFICATION

I CERTIFY THAT THIS INDIVIDUAL IS:

☐ Free from infectious diseases, in good health and able to provide care to a child.

☐ In poor health and unable to provide care to a child.

_____ _____

Physician's Signature Date