AGAPE
THE ASSOCIATION FOR GUIDANCE, AID, PLACEMENT AND EMPATHY, INC.
4555 Trousdale Drive, Nashville, TN 37204 Phone: 615-781-3000

Medical History of Adult to be completed by Patient
(FRONT)

______________________________ ______________ ______________________________
Name **DOB** **Address**

The report of a current physical examination and full family medical history are required as an essential part of the appraisal of a home and family for the placement of a child or for employment and volunteer service.

FAMILY HISTORY

Relation Age	Health Status	Age at Death	Cause of death
Father			
Mother			
Spouse			
Siblings			
Children			

Family History:	Yes	No
Tuberculosis	( )	( )
Diabetes	( )	( )
Cancer	( )	( )
Epilepsy/Seizures	( )	( )
Kidney Disease	( )	( )
Heart Disease/High Blood Pressure	( )	( )
Asthma	( )	( )
Thyroid Disease	( )	( )
Nervous Disorder	( )	( )
Alcoholism/Drug Abuse	( )	( )
Mental Illness/ADHD/ADD	( )	( )
Intellectual/Dev Disability	( )	( )
Sickle Cell Disease/Trait	( )	( )

INDIVIDUAL HISTORY:
Check as applicable whether you have now or have ever had:

Explain any “yes” answer:
____
____
____
____
____
____

	Yes	No		Yes	No
Heart Disease	( )	( )	Kidney Disease	( )	( )
Tumor or Malignancy	( )	( )	Multiple Sclerosis	( )	( )
Venereal Disease	( )	( )	Muscular Dystrophy	( )	( )
Hypertension	( )	( )	Epilepsy or Convulsions	( )	( )
Ulcers	( )	( )	Thyroid Disorder	( )	( )
Diabetes	( )	( )	Migraine	( )	( )
Tuberculosis	( )	( )	Asthma	( )	( )
Anemia	( )	( )	Alcohol or Drug Addiction	( )	( )
Arthritis	( )	( )	Mental Illness	( )	( )
Hepatitis	( )	( )	Depression/Bi-Polar	( )	( )
HIV	( )	( )	ADHD/ADD	( )	( )

List and give dates of any surgeries, injuries, or illnesses requiring hospital care:____
____

Prescribed medications (reason/dosage):____
____

Mental health treatment or diagnosis (ex. Anxiety, depression) & dates: ______________________________
____

Counseling in the past 3 years: ____
____

Alcohol/Drug History and Frequency

_ **Alcohol** ______________________________
_ **Marijuana**______________________________
_ **Barbiturates** ___________________________
_ **Amphetamines** __________________________
_ **Huffing** ________________________________

_ **Hallucinogens** ______________________________________
_ **Sedatives** ____
_ **Steroids** ____
_ **Tobacco/smoking/vaping:** ______________________________
_ **Opiates** ____

(BACK)

Medical Examination of Patient

(This side will be completed by the Physician)

A. ______________________________ ______________ ______________
Name **Birthdate** **Address**

B. **MEDICAL EXAMINATION**: (To be completed on all patients) Date of Exam: ______________

Height __________ **Weight** ____________ **BP** __________ **P** _______ **Temp** _______ **Resp**. ________

Vision screening: Right:_______ Left: _______ **Hearing screening**: Right: [ ] Pass [ ] Fail Left: [ ] Pass [ ] Fail

How long have you known patient? _________________

Does this examination reveal any evidence of past or present disease of:

	Yes	No
Skin or Lymph Glands	( )	( )
Eyes, Ears, Nose, Throat	( )	( )
Heart and Lungs	( )	( )
Stomach & Abdomen	( )	( )
Genitourinary System	( )	( )
Central Nervous System	( )	( )
Venereal Disease	( )	( )
Other	( )	( )

Do you consider patient to be:	Yes	No
Emotionally Stable?	( )	( )
Well-adjusted?	( )	( )
Capable of meeting needs of growing children?	( )	( )
Is marriage stable?	( )	( )

Give additional information if indicated including current medical concerns. Use additional sheet if needed.

____

____

LABORATORY FINDINGS:

Tuberculin Skin Test results (required)____

TDap vaccination (required) date:______________________ **Influenza vaccination (required) date:**___________________

Results of other tests, as applicable CBC__________ **Metabolic panel** __________ **Cholesterol** ____________________

VDRL/GC/Chalmydia (if at risk)_________________**Other**__________________________

Specify any physical, mental, or emotional problems which would affect this person's ability to care for a child. If the patient is identified as other adult living in home, indicate conditions detrimental to a child's placement in home:

____

____

(Omit this item for "other adult" living in home or when exam is for the purpose of employment or volunteer service)
*** On the basis of this examination and my knowledge of this patient, I recommend ______ I do not recommend _____ him/her as a foster or adoptive parent for children. Comments: ____

____

Please Print

______________________________ ______________________________
Signature of Physician Name

____
Address

______________________________ ______________________________
Date Phone number

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