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												
		and full family n		story are rec	quired as an essential part of the app	oraisal of	a home										
and family for the placeme	ent of a child or fo	r employment and	l voluntee	r service.	-												
FAMILY HISTORY																	
Relation Age	Health Status	Age at Death	Cause	of death	Family History:	Yes	No										
Father					Tuberculosis	()	()										
Mother					Diabetes	()	()										
Spouse					Cancer	()	()										
Siblings					Epilepsy/Seizures	()	()										
					Kidney Disease	()	()										
					Heart Disease/High Blood Pressure	()	()										
Children					Asthma	()	()										
					Thyroid Disease	()	()										
					Nervous Disorder	()	()										
					Alcoholism/Drug Abuse	()	()										
					Mental Illness/ADHD/ADD	` ′	()										
					Intellectual/Dev Disability	()	()										
					Sickle Cell Disease/Trait	()	()										
you have now or have ever nad: Explain any "yes" answer: List and give dates of any	Venereal Hyperten Ulcers Diabetes Tubercul Anemia Arthritis Hepatitis HIV v surgeries, injur	Malignancy Disease sion osis	() () () () () () () () equiring I	() () () () () () () () ()	Kidney Disease Multiple Sclerosis Muscular Dystrophy Epilepsy or Convulsions Thyroid Disorder Migraine Asthma Alcohol or Drug Addiction Mental Illness Depression/Bi-Polar ADHD/ADD	() () () () () () () () ()	() () () () () () () () ()										
Prescribed medications (1																	
Mental health treatment	or diagnosis (ex.	Anxiety, depress	sion) & da	ites:													
Counseling in the past 3 y	years:																
Alcohol/Drug History and	d Frequency																
•			Hallu	cinogens													
Marijuana Barbiturates Amphetamines			_ Sedatives Steroids Tobacco/smoking/vaping:														
										Huffing			_ Opia	tes			

Revision 7/2019

(BACK)

Medical Examination of Patient

(This side will be completed by the Physician)

Height Weight BP P Temp Resp. Vision screening: Right: Left: Hearing screening: Right: [] Pass [] Fail Left: [] Pass [] How long have you known patient? Does this examination reveal any evidence of past or present disease of: Yes No Yes No Skin or Lymph Glands () () Do you consider patient to be: Fyes, Fars, Nose, Throat () () Emotionally Stable? () () () Heart and Lungs () () Well-adjusted? () () Stomach & Abdomen () () Ganable of meeting needs of () () Genitourinary System () () Is marriage stable? () () Well-adjusted? () () Well-adjusted? () () Genitourinary System () () Is marriage stable? () () Well-adjusted? () () Genitourinary System () () Is marriage stable? () () Well-adjusted? () () Well-adjusted? () () Well-adjusted? () () Well-adjusted? () () Genitourinary System () () Is marriage stable? () () Well-adjusted? () () () () Well-adjusted? () () () Well-adjusted? () () () () () Well-adjusted? () () () () () Well-adjusted? () () () () () () Well-adjusted? () () () () () () () () () Well-adjusted? () () () () () () () () () () () () ()	AName				Birthdate		Address	
Height	B MEDICAL EX	XAMINATION: (To b	ne completed o	on all patients) Date	of Exam:			
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No] Pass [] Fa
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