

CERTIFICATE OF GENERAL PHYSICAL EXAMINATION  
FOR ADOPTION APPLICANT

**TO EXAMINING PHYSICIAN:**

Your medical report is of paramount importance to the China Centre of Adoption Affairs in its examination of the adoption qualification of the adopters. You are kindly requested to fill in all of the blanks. Please print clearly or type all information. Thank you for your cooperation.

Applicant's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

**MEDICAL HISTORY (please circle yes or no):**

Has the applicant ever had...?

Tuberculosis?	No/ Yes	Tumor?	No/ Yes
Heart Disease?	No/ Yes	Liver Disease?	No/ Yes
Sexual Disease?	No/ Yes	Neuropathy?	No/ Yes
Mental Disease?	No/ Yes	Other Communicable Disease?	No/ Yes
Alcoholism or Substance Abuse?	No/ Yes	Any Genetic Disease?	No/ Yes
Any Operation(s)?	No/ Yes (if yes, please list what for and date) _____		

**PHYSICAL EXAMINATION (Please circle either "normal" or "abnormal". Do not leave any spaces blank. Please do not refer to attachments or pending results):**

Height \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Hearing: (L) Normal/Abnormal (R) Normal/Abnormal  
Vision: (L) \_\_\_\_\_ (R) \_\_\_\_\_ Heart: Normal/Abnormal Liver: Normal/Abnormal  
Lung: Normal/Abnormal Lymph: Normal/Abnormal Thyroid: Normal/Abnormal  
Nervous System: Normal/Abnormal Blood Test (date of test): \_\_\_\_\_ Routine Blood Test: Normal/Abnormal  
HbsAg: Normal/Abnormal Liver Function: Normal/Abnormal  
Urinalysis (date of test): \_\_\_\_\_ Routine Urine Test: Normal/Abnormal  
HIV Test (date of test): \_\_\_\_\_ Result: Negative/Positive

Is the applicant taking any medication? No/Yes If yes, for what purpose? \_\_\_\_\_

Please list dosage and efficacy: \_\_\_\_\_

Are there any physical, mental, or psychological unfavorable elements of the adoption applicant, which will affect the upbringing of a child? \_\_\_\_\_

Is the adoption applicant's state of health suitable for raising a child? \_\_\_\_\_

**PHYSICIAN'S STATEMENT (Please type or print clearly):**

Signature: \_\_\_\_\_ MD License#: \_\_\_\_\_ Date: \_\_\_\_\_