

Certificate of General Physical Examination for Adoption Applicant

To examining physician:

Your medical report is of paramount importance to the China Centre for Children's Welfare and Adoption, CCCWA, in its examination of the adoption qualification of the adopters. You are kindly requested to fill in all the blanks. Thank you for your cooperation.

Applicant's name: _____ DOB: _____

Address: _____

| Have you ever had | YES | NO | | YES | NO |
|----------------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | Tumor | <input type="checkbox"/> | <input type="checkbox"/> |
| Neuropathy | <input type="checkbox"/> | <input type="checkbox"/> | Heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Disease | <input type="checkbox"/> | <input type="checkbox"/> | Sexual disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Other communicable disease | <input type="checkbox"/> | <input type="checkbox"/> | Liver disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Alcoholism or abuse of substance | <input type="checkbox"/> | <input type="checkbox"/> | Any genetic disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Any operation | <input type="checkbox"/> | <input type="checkbox"/> | | | |

If YES: _____

PHYSICAL EXAMINATION Date: _____

Height: _____ cm Weight: _____ kilos Blood pressure: _____

Vision
Left: _____ Right: _____

| | NORMAL | ABNORMAL | | Negative | Positive |
|--------------------|--------------------------|--------------------------|-----|--------------------------|--------------------------|
| Hearing Left | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Hearing Right | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Heart | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Liver | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Lymph | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Thyroid | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Lung | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Nerve system | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Routine Urine test | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Liver Function | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| Blood test | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| HbsAg | <input type="checkbox"/> | <input type="checkbox"/> | HIV | <input type="checkbox"/> | <input type="checkbox"/> |

Urinalysis date: _____ Blood test date: _____ HIV test date: _____

Is the patient taking any medication? If so, for what purpose? _____

Physical test result:

Are there any physical, mental or psychological unfavourable elements of the adoption applicant, which will affect the upbringing of the child? YES NO

Is the adoption applicant's state of health suitable for raising a child? YES NO

Date: _____ Physicians name: _____