



HEALTH QUESTIONNAIRE – PART A (to be completed by the GP)

Client name _____ age _____
Date of examination _____

Family history

Have there been any serious or inherited diseases in the client's family?

YES NO

If YES, please specify:

Personal history

Has the client suffered from any serious or inherited diseases in the past?

YES NO

If YES, please specify:

Does the client suffer from any diseases at present?

YES NO

If YES, please specify:

Has the client been treated for infertility / sterility? YES NO

Has the cause of infertility / sterility been established? YES NO

Can the client, if treated adequately, conceive a child? YES NO

Has the client suffered a serious injury in the past that may affect his/her role of an adoptive parent? YES NO

If YES, please specify:

Body examination

height _____ weight _____

musculoskeletal system _____ nervous system _____

ears _____ eyes _____

nose and neck _____ oral cavity _____

thyroid gland _____ cardiovascular system _____

blood pressure _____ respiratory system _____

abdomen _____ urogenital system _____

HIV test performed on _____ positive negative

Hepatitis C performed on _____ positive negative

Does the client suffer from any contagious diseases, specific illness or condition that may pose a serious risk of transmission? YES NO

If YES, please explain briefly:

Does the client permanently use medication? YES NO

If YES, please explain:

Addictions (drug, alcohol, gaming, other)

Has the client been treated in the past? YES NO I DO NOT KNOW

Does the client undergo treatment currently? YES NO I DO NOT KNOW

If YES, please explain: _____

Evaluation of the overall health condition

client is healthy

client is treated and the treatment will not limit the client's role as an adoptive parent

client has a medical condition and his/her treatment may significantly affect his role as an adoptive parent

Have you given the client any recommendations regarding medical care? YES NO

If YES, please explain:

signature, seal of the GP _____

HEALTH QUESTIONNAIRE – PART B
(to be completed by the applicant)

Do you have any health problems and limitations (allergies, asthma, etc.)? YES NO

If YES, please specify:

Do you use any medication? YES NO

If YES, please specify:

Do you regularly visit a specialist? YES NO

If YES, please specify:

Have you been treated in the past or are you treated for addictions? YES NO

If YES, please specify:

Do you feel healthy and do you feel you are able to take care of the adopted child?

YES NO

If NO, please specify:

date _____ signature _____