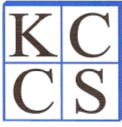

KEMP COUNSELING AND CONSULTING SERVICES
Shawna Kemp, M.S.W., L.C.S.W.
Licensed Psychotherapist

MEDICAL STATEMENT

(To be completed by physician)
(Examination must not be performed by a relative of the patient)

Patient's Name: ________________________________ Date of Birth: ________________

Height: ____________________________ Weight: ______________________________

Pulse: _____________________________ Blood Purse: __________________________

Vision: ____________________________ Hearing: _____________________________

Heart: _____________________________ Lungs: _______________________________

Skin: ______________________________ Orthopedic Defects: ____________________

Teeth: _____________________________ Endocrine System: _____________________

Abdomen: ___________________________ Nervous System: _______________________

Allergies: __________________________ Cancer: ______________________________

Mental Illness: ______________________ Surgeries: ____________________________

Chronic Condition: ___________________ Other: _______________________________

Tuberculin Test:
Date: ___________________ Results: _______________________________________

Chest x-rays (required if TB is positive): ____

Fertility Status: ____

Pap smear: ____

Length of time patient has received care from you and follow-up plan, if any: _____________

____

Is the patient in overall good health at the present time? ______________________________

In your opinion does the patient have normal life expectancy? __________________________

Could you add anything related to the personality, physical condition or past health history, not already explained which would affect the patient's ability to take on the responsibilities of parenthood?

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Physician's Printed Name: ____________________________________

Physician's Signature: ____________________________________ Date: ____________

Address: ____

Telephone: ____________________________