HOPEFUL MAMA FOUNDATION™

2025 Medical History & Evaluation Form

Applicants are required to submit a completed Medical History & Evaluation Form when applying for a Hopeful Mama Foundation financial grant. The attached form should be completed and submitted with your online application.

You should complete Part I prior to submitting the evaluation form to your licensed healthcare provider. Part II, the "Health History" and Part III, “Medical Evaluation” must be completed by a licensed healthcare provider, no more than one year before the grant start date.

The purpose of this form is to confirm health status, upon which an awarded grant is contingent.

The Medical Evaluation Form and Licensed Healthcare Provider Statement should be completed by a licensed healthcare provider (MD/DO/DNP/FNP/PAC), who is not a member of your family. Violation of this policy will result in the revocation of your grant, if selected. If the forms are completed by a LPN/RN/MA, it must be cosigned by a licensed healthcare provider.

INSTRUCTIONS TO APPLICANTS:

- Complete Part I on your own prior to the physical examination (ONLY page 2). If a question does not pertain to you, please write in N/A.
- Sign and date Part V, the applicant’s statement, on page 7.
- Provide Part II and III to your healthcare provider to complete and ensure they sign Part IV.
- Although physicians' offices sometimes use a LPN or RN to help perform the evaluations, *only a licensed healthcare provider* (*MD/DO/DNP/FNP/PAC) may sign the form*.

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PART I: TO BE COMPLETED BY APPLICANT (*Please type or print*)

NAME: _____ First/Last Age	
DATE OF BIRTH: _____ Month/Day/Year	SEX: ☐ Male ☐ Female _____
GRANT CYCLE: _____ Month/Year	APPLIED BEFORE: _____ YES/NO

Names of all fertility professionals consulted within the last year, including your Primary Care Physician.

NAME	SPECIALTY or Primary Care	TELEPHONE #:
	Primary Care Physician	

DATE OF LAST MENSTRUAL CYCLE: _____	AGE OF FIRST MENSTRUATION _____ AGE OF MENOPAUSE _____
NUMBER OF PREGNANCIES _____ NUMBER OF LIVE BIRTHS _____ NUMBER OF TERMINATIONS _____	NUMBER OF MISCARRIAGES _____ NUMBER OF STILLBIRTHS _____ NUMBER OF ECTOPIC/TUBAL _____

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SUBSTANCE ABUSE HISTORY Please provide an answer to each item.						
SUBSTANCE:	EVER USED?	AMOUNT	FREQUENCY	DURATION	FIRST USE	LAST USE
Caffeine						
Tobacco						
Alcohol						
Marijuana						
Opioids/Narcotics						
Amphetamines						
Cocaine						
Hallucinogens						
Others:						

I certify that I have reviewed the information supplied by me and that it is true and complete to the best of my knowledge.

Applicant Printed Name: _____

Applicant Signature: _____

Date: _____

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INSTRUCTIONS FOR THE EXAMINING HEALTHCARE PROVIDER:

Please evaluate thoroughly all items listed on the examination form. It is most important that you:

1. Comment on all items checked "YES" on the Medical History section (below).
2. Record all physical findings after completing the examination as requested. *Only the results of a physical exam performed no more than one year prior to the grant start date may be reported.*
3. Comment on all indicated follow-up examinations and conditions that may require frequent observation or prolonged treatment. Please indicate your overall opinion of the applicant's health in Part IV.
4. Sign and date the portion of the examination form that you completed.

PART II: TO BE COMPLETED BY LICENSED HEALTHCARE PROVIDER

To be completed by the applicant's healthcare provider, in consultation for fertility treatments. For any items checked "YES," the healthcare provider must provide further explanation of the status of the condition and/or the prognosis and how it may or may not impact fertility treatments.

MEDICAL HISTORY					
Does the applicant now have, or have they ever had, any of the conditions or symptoms listed below? Indicate "YES" or "NO". "YES" answers MUST be explained in the space provided following this section.					
CHECK EACH ITEM	YES	NO		YES	NO
Frequent or severe headaches			Fainting spells (syncope)		
Epilepsy or seizures			Heart condition incl. arrhythmia, angina, heart attack, murmur, and heart failure		
Stroke			Eye disease or vision impairment (other than corrected refractive error)		
Hearing impairment			Severe allergies, including environmental, insect stings, food, and medication		
Tooth or gum disease (periodontal disease)			Tropical diseases, incl. malaria, amoebiasis, leprosy, filariasis, etc.		
Asthma, emphysema, persistent cough, or other lung conditions.			Depression, anxiety, excessive worry, schizophrenia, psychosis		
Tuberculosis			Drug or alcohol abuse		
High blood pressure			Sickle cell anemia, excessive bleeding, blood clots or other blood disorder		
Gynecological disorder			Cancer in any form		
Other hormonal disorders, incl. thyroid			HIV infection, AIDS		
Diabetes mellitus (high blood sugar, sugar in urine)			Severe skin disorder		

If answered “YES” to any of the above, please explain in detail, including dates of occurrence, treatment, and outcome.

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MEDICAL EVALUATION FORM

This Medical Evaluation Form must be completed by a licensed healthcare provider after reviewing the applicant's medical history (Part I) and conducting a physical examination (or an exam within the past year). The healthcare provider must comment on all positive and/or significant findings and sign where indicated.
Please type or print clearly in ink.

APPLICANT'S NAME: _____
First/Last

HEIGHT: _____ WEIGHT: _____

BLOOD PRESSURE: _____ BMI: _____

CLINICAL EVALUATION

Please provide an answer to each item.
Abnormal findings must be fully explained in the space provided.

	NORMAL	ABNORMAL	DESCRIBE ABNORMAL FINDINGS
Head and neck			
Hearing Acuity			
Visual Acuity			
Lungs and chest			
Heart and vascular system			
Abdomen			
Breasts			
Genitourinary/Gynecologic			
Musculoskeletal			
Lymphatic			
Neurologic			
Skin			
Appearance			
Affect			
Orientation			
Mood			
Thought Content			
Thought Process			
Thought Disorder			
Concentration			
Attention			
Behavior			
Speech			
Judgement			
Insight			
Memory			

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PART III. MEDICAL EVALUATION TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER

Has the applicant ever had any significant or serious illness or injury not mentioned above? If so, explain the nature of the problem and outcomes.
Please explain any operations (surgical procedures) the applicant has had, including dates and major complications.
Has the applicant ever been hospitalized for any reason? If so, explain what condition, provide dates, and explain the outcome.
Has the applicant ever seen a psychiatrist, psychologist, or psychotherapist for a diagnosed mental health condition? If so, explain for what condition and provide dates of treatment and explain the outcome.
List all the medications taken by the applicant in the past year (do not include fertility treatment medications).
List all specific fertility medications currently being taken by the applicant.
List all medical devices being used by the applicant (for example: insulin pump, prostheses, nebulizers).

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PART IV. LICENSED HEALTHCARE PROVIDER STATEMENT:

Based on your physical examination and on the applicant's physical and emotional history, do you consider the applicant physically and emotionally able to undergo fertility treatment and/or continue to advanced fertility treatments? (Circle one) YES or NO

If no, please explain:

MEDICAL PROFESSIONAL COMPLETING THE MEDICAL EVALUATION FORM:

Name	Position	Date

Printed Name of Licensed Healthcare Provider:

_____Date:_____

Signature of Licensed Healthcare Provider:

_____Telephone:_____

Clinic Name and Address: _____

_____

PART V. APPLICANT'S STATEMENT:

I certify that I have reviewed the information provided by me in Part I and by my healthcare provider in Part II, and that it is true and complete to the best of my knowledge. I understand that this information will be shared with the Hopeful Mama Foundation Board of Directors for the grant selection process. I acknowledge that falsifying or knowingly omitting critical medical information may jeopardize my grant application.

Signature: _____Date:_____

Privacy Policy: The information provided by you and your healthcare provider will remain confidential and will be shared with the Hopeful Mama Foundation Board of Directors for grant administration purposes.