Birth Parent’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Child(rens) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| MEDICAL HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES |
| Indicate by checking appropriate box if YOU or any of your RELATIVES (i.e., your parents, sisters, brothers, aunts, uncles, grandparents, otherchildren born to you, etc.) have had or now have the medical conditions listed below. Indicate person’s relationship to you. Each birth parent must complete one of these forms for the child or children for whom you are relinquishing your parental rights. Please complete Comments Section. If a medical condition resulted in death of a family member, indicate this and the person’s approximate age at time of death in Comments Sections.  |
| MEDICAL CONDITION | NO | **Not****Known** | **YES****Self** | YES – RELATIVE(Specify Relationship**)** | COMMENTS |
| A. BIRTH DEFECTS |  |  |  |  |  |
|  1. Clubfoot or any orthopedic problem (i.e., flat footed, etc.) Bilateral vs. uni-lateral. |  |  |  |  |  |
|  2. Cleft lip or cleft palate |  |  |  |  |  |
|  3. Down Syndrome |  |  |  |  |  |
|  4. Other chromosome abnormality Name, if known: |  |  |  |  |  |
|  5. Hydrocephalus |  |  |  |  |  |
|  6. Muscular dystrophy |  |  |  |  | Parts of body involved? Age at onset? |
|  7. Dwarfism |  |  |  |  |  |
|  8. Spinal bifida |  |  |  |  |  |
|  9. Congenital heart defect |  |  |  |  |  |
|  10. Other (explain) |  |  |  |  |  |
| B. ALLERGIES |  |  |  |  |  |
|  1. Eczema or other skin condition |  |  |  |  | Any cause known? What treatment? What medication? |
|  2. Hay fever or other allergy |  |  |  |  | Any cause known? What treatment? What medication? |
|  3. Drug allergy |  |  |  |  | To what drugs? |
|  4. Food allergy |  |  |  |  | To what foods? |
|  5. Other (explain) |  |  |  |  |  |
| C. EYE, DENTAL, EAR, |  |  |  |  |  |
|  1. Blindness, glaucoma, color blindness or other visual problems |  |  |  |  |  |
|  2. Corrective glasses or contact lenses |  |  |  |  | At what age were prescription lenses necessary? |
|  Nearsighted [ ]  Farsighted [ ]  |  |  |  |  |  |
|  Astigmatism [ ]  (inability to focus) |  |  |  |  |  |
|  Strabismus [ ]  (crosseye) |  |  |  |  |  |
|  3. Braces on teeth or other orthodontia work |  |  |  |  | If so, what orthodontic work and for how long? |

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| MEDICAL HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (…Continued) |
| MEDICAL CONDITION | NO | **Not****Known** | **YES****Self** | YES – RELATIVE(Specify Relationship**)** | COMMENTS |
|  4. Other dental problems |  |  |  |  |  |
|  5. Deafness or other ear problems Congenital vs. other |  |  |  |  |  |
| D. DEVELOPMENTAL DISORDERS |  |  |  |  |  |
|  1. Speech problems |  |  |  |  |  |
|  2. Learning disability |  |  |  |  | Any diagnosis? Hospitalization? |
|  3. Retardation: mental or physical |  |  |  |  |  |
|  4. Special education   |  |  |  |  | Age at onset? |
|  5. Other (explain) |  |  |  |  |  |
| E. CIRCULATORY DISORDERS |  |  |  |  |  |
|  1. Hemophilia |  |  |  |  |  |
|  2. Sickle cell anemia or trait |  |  |  |  | Disease or carrier status? |
|  3. Hypertension (high blood pressure) |  |  |  |  | Age at onset? What treatment? Hospitalization? |
|  4. Stroke |  |  |  |  | Age at onset? What treatment? Hospitalization |
|  5. Heart attack (coronary) |  |  |  |  |  |
|  6. Heart disease |  |  |  |  | Age at onset? What treatment? Hospitalization |
|  7. Other (explain) |  |  |  |  |  |
| F. HORMONAL DISORDERS |  |  |  |  |  |
|  1. Diabetes |  |  |  |  | Age at onset? What treatment? |
|  2. Thyroid disorder |  |  |  |  | Age at onset? What treatment? |
|  3. Obesity (overweight) |  |  |  |  |  |
|  4. Other (explain) |  |  |  |  |  |
| G. RESPIRATORY DISORDERS |  |  |  |  |  |
|  1. Asthma |  |  |  |  | Any cause known? What treatment? |
|  2. Emphysema |  |  |  |  | Age at onset? |
|  3. Other (explain) |  |  |  |  |  |
| H. MENTAL AND BEHAVIORAL DISORDERS |  |  |  |  |  |
|  1. Diagnosed schizophrenia |  |  |  |  | Age at onset? What treatment? Hospitalization? |
|  2. Diagnosed Bi-polar |  |  |  |  | Age at onset? What treatment? Hospitalization? |
|  3. Other mental illness. Describe, using additional page, if necessary |  |  |  |  |  |
|  4. Alcoholism or heavy drinking |  |  |  |  |  |
|  5. Drug usage, both legal & illegal |  |  |  |  | Kind, amount, and when taken? |

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| MEDICAL HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (…Continued) |
| MEDICAL CONDITION | NO | **Not****Known** | **YES****Self** | YES – RELATIVE(Specify Relationship**)** | COMMENTS |
| I. LYMPHATIC DISORDERS |  |  |  |  |  |
|  1. Cancer |  |  |  |  | What kind? Age at onset? What part of body? |
|  2. Tumors |  |  |  |  | What kind? Age at onset? What part of body? |
|  3. Hodgkin’s disease |  |  |  |  |  |
|  4. Other (explain) |  |  |  |  |  |
| J. NERVOUS SYSTEM DISORDERS |  |  |  |  |  |
|  1. Multiple sclerosis |  |  |  |  | Parts of body involved? Age at onset? |
|  2. Huntington’s disease |  |  |  |  |  |
|  3. Cerebral palsy |  |  |  |  |  |
|  4. Seizures or convulsions (Epilepsy) |  |  |  |  | Age at onset? What treatment? Frequency? |
|  5. Other (explain) |  |  |  |  |  |
| K. INFECTION, HOSPITALIZATION |  |  |  |  |  |
|  1. Repeated attacks of fever with  known infection |  |  |  |  | Diagnosis? |
|  2. Repeated severe infection necessitating hospitalization |  |  |  |  | Age? Number of hospitalizations? |
|  3. Hospitalization, operation, or injury |  |  |  |  | What for? When? |
|  4. Tuberculosis |  |  |  |  | Age at onset? What kind? What part of body? |
|  5. Other (explain) |  |  |  |  |  |
| L. OTHER MEDICAL OR HEALTH PROBLEMS |  |  |  |  |  |
|  1. Arthritis |  |  |  |  | What kind? Age at onset? What part of body? |
|  2. Kidney disease (renal) |  |  |  |  | Age at onset? What treatment? |
|  3. Cystic fibrosis  |  |  |  |  | What kind? Age at onset? What part of body? |
|  4. Miscarriages  |  |  |  |  | Number of pregnancies, number of live births |
|  5. Alzheimer’s |  |  |  |  |  |
|  6. Depression/Suicide |  |  |  |  |  |
|  7. Abuse/neglect |  |  |  |  |  |
|  8. Smoking |  |  |  |  |  |
|  9. Other |  |  |  |  | Please list premature deaths of close relative and other children born to you including age and cause of death.  |

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth parent who completed this form relationship to the child (birth mother or father)