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MEDICAL HISTORY REPORT

Birth Parent's Name: _____

Birth Child(rens) Name: _____

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, other children 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 REPORT

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?

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)