Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

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Use the Tab Key to go from one field to the next

Birth Parent Updated Medical History

Reset Form

Please ***PRINT*** and complete as many items as known, required items are marked (*required)

Name of Child on Original Birth Record: _____
First name Middle name Last name (*required)

City/Town of Birth: _____ Hospital: _____

Date of Birth: _____ Sex: ☑ Female ☐ Male
(mm/dd/yyyy)

Birth Parent's Name (As shown on child's birth record) _____

Person completing this form is: ☐ Biological Birth Parent ☐ Other Biological Birth Parent

Please indicate if information is unknown ("unk") or not available ("N/A").

MEDICAL CONDITIONS OF CHILD'S BIOLOGICAL FAMILY

Birth Parent's Family and Other Birth Parent's Family
*Please list relationship to child; e.g., parent, grandparent, aunt, uncle, sibling. If additional space is needed, please attach a separate sheet when filing this form.

Condition	Birth Parent's Family*	Other Birth Parent's Family*	Comments (if condition resulted in death, note here)
1. Respiratory			
Allergies			
Asthma			
Bronchitis			
Emphysema			
Tuberculosis			
Cystic Fibrosis			
Other			
2. Gastrointestinal			
Ulcers			
Inflammatory Bowel			
Cleft lip or palate			
Other			
3. Cardiovascular			
High blood pressure			
Heart attack			
Stroke			
Congestive heart failure			
Atherosclerosis			
Heart rhythm abnormality			
Congenital heart defect			

Name of child on original birth record:

_____

DOB: _____ Certificate number: _____

Other **Condition**	Birth Parent's Family*	Other Birth Parent's Family*	Comments (if condition resulted in death, note here)
4. Immune/Hematological			
Mononucleosis			
Hemophilia			
Leukemia			
Lymphomas			
Hodgkin's disease			
Other cancer (type?)			
5. Renal			
Kidney failure/ dialysis/transplant			
Other kidney problems			
6. Liver Disease			
Hepatitis (specify type)			
Cirrhosis			
Other liver disease			
7. Central Nervous System			
Epilepsy			
Hydrocephalus			
Multiple Sclerosis			
Huntington's Chorea			
Seizures/ convulsions			
Other			
8. Endocrine			
Diabetes (adult or juvenile) - list treatment			
Thyroid (hyper/hypo)			
Adrenal			
Other hormonal disorder			
9. Muscular/Skeletal			
Club foot			
Scoliosis (curvature of the spine)			
Arthritis (osteo or rheumatoid)			
Lupus			
Other paralysis or crippling disorder			

Name of child on original birth record:

_____

DOB: _____ Certificate number: _____

*Please list relationship to child; e.g., parent, grandparent, aunt, uncle, sibling. If additional space is needed, please attach separate sheet when filing this form.

Condition	Birth Parent's Family*	Other Birth Parent's Family*	Comments (if condition resulted in death, note here)
10. Neuromuscular			
Cerebral Palsy			
Muscular Dystrophy			
Spina Bifida			
Other			
11. Visual/Auditory/Speech			
Blindness			
Glaucoma			
Cataracts or other eye problems (specify)			
Deafness or other hearing problems (specify)			
Speech problems			
Other			
Other Conditions			
12. Mental illness List type: (e.g., depression, bipolar, schizophrenia)			
13. Alcohol or drug abuse			
14. Eating disorders			
15. Learning disability			
16. Mental retardation			
17. Eczema or other skin conditions			
18. Give age at death and cause of death of child's grand-parent, aunt, uncle, and siblings (if applicable)	Grandparent	Grandparent	
	Grandparent	Grandparent	
	Aunt	Aunt	
	Uncle	Uncle	
	Sibling	Sibling	

*Please list relationship to child; e.g. parent, grandparent, aunt, uncle, sibling. If additional space is needed, please attach a separate sheet when filing this form.

Name of child on original birth record:

_____

DOB: _____ Certificate number: _____

Drug and Alcohol Use During Pregnancy	Birth Parent's Family*	Other Birth Parent's Family*	Comments Kind taken, when, amount and frequency (where applicable)
Prescription drugs taken during pregnancy			
Non-prescription drugs taken during pregnancy			
Alcohol use during pregnancy			
Marijuana use during pregnancy			
Amphetamines used during pregnancy			
Barbiturates used during pregnancy			

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Information on this Pregnancy

Was adoptee's other biological parent aware of this pregnancy? ☐ Yes ☐ No

Was birth parent exposed during pregnancy to the following? ☐ X-Ray ☐ Electrocardiogram ☐ Radiation

☐ Other (Please specify) _____

Did birth parent have prenatal care? ☐ Yes ☐ No

If yes, in what month did prenatal care begin? _____

Were there any complications? ☐ Yes ☐ No If yes, please specify. _____

_____

_____

Name of child on original birth record:

_____

DOB: _____ Certificate number: _____

Other Information on Birth Parents*

Information given should be at time of child's birth. Do not include identifying information.

Birth Parent's Information		
Height	Weight	Body shape/build
Eye color	Hair color	Skin color
Age	Ethnic background	Nationality (citizenship)
Religion	Number of school years completed	RH factor
Blood type ☐ O ☐ A ☐ B ☐ AB	Race ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Other	☐ Asian ☐ Native Hawaiian or other Pacific Islander
Other Birth Parent's Information		
Height	Weight	Body shape/build
Eye color	Hair color	Skin Color
Age	Ethnic background	Nationality (citizenship)
Religion	Number of school years completed	RH factor
Blood type ☐ O ☐ A ☐ B ☐ AB	Race ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Other	☐ Asian ☐ Native Hawaiian or other Pacific Islander

*If additional space is needed, please attach a separate sheet when filing this form.

Official Use Only	
Certificate Number	
Date Received	
Date Issued	