



## Birth Parent Updated Medical History

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: _____ (mm/dd/yyyy)		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male
Birth Parent's Name (As shown on child's birth record) _____		
Person completing this form is: <input type="checkbox"/> Biological Birth Parent <input type="checkbox"/> 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)
<b>1. Respiratory</b>			
Allergies			
Asthma			
Bronchitis			
Emphysema			
Tuberculosis			
Cystic Fibrosis			
Other			
<b>2. Gastrointestinal</b>			
Ulcers			
Inflammatory Bowel			
Cleft lip or palate			
Other			
<b>3. Cardiovascular</b>			
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			Comments (if condition resulted in death, note here)
<b>Condition</b>	Birth Parent's Family*	Other Birth Parent's Family*	
<b>4. Immune/Hematological</b>			
Mononucleosis			
Hemophilia			
Leukemia			
Lymphomas			
Hodgkin's disease			
Other cancer (type?)			
<b>5. Renal</b>			
Kidney failure/ dialysis/transplant			
Other kidney problems			
<b>6. Liver Disease</b>			
Hepatitis (specify type)			
Cirrhosis			
Other liver disease			
<b>7. Central Nervous System</b>			
Epilepsy			
Hydrocephalus			
Multiple Sclerosis			
Huntington's Chorea			
Seizures/ convulsions			
Other			
<b>8. Endocrine</b>			
Diabetes (adult or juvenile) - list treatment			
Thyroid (hyper/hypo)			
Adrenal			
Other hormonal disorder			
<b>9. Muscular/Skeletal</b>			
Club foot			
Scoliosis (curvature of the spine)			
Arthritis (osteo or rheumatoid)			
Lupus			
Other paralysis or crippling disorder			

Name of child on original birth record:

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\*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 grandparent, 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: \_\_\_\_\_

<b>Drug and Alcohol Use During Pregnancy</b>	<b>Birth Parent's Family*</b>	<b>Other Birth Parent's Family*</b>	<b>Comments Kind taken, when, amount and frequency (where applicable)</b>
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 <input type="checkbox"/> White <input type="checkbox"/> Black American Indian/Alaskan Native Other	Asian <input type="checkbox"/> 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  <input type="checkbox"/> O <input type="checkbox"/> A <input type="checkbox"/> B      AB	Race <input type="checkbox"/> White <input type="checkbox"/> Black American Indian/Alaskan Native Other	<input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander

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Official Use Only	
Certificate Number	
Date Received	
Date Issued	