Birth Mother's Pregnancy History
Medical

*Print Full name*_____

Signed _____

*Date form completed*_____

MOTHER'S BIRTH HISTORY

Your weight at birth _____

Your length at birth _____

Were you born Full term ☐ Premature ☐ Postmature ☐

Were you delivered by Vaginal (normal) delivery ☐ Caesarian (C-Section) ☐

Any complications with your delivery or birth? Yes ☐ No ☐

If yes, please describe: _____

PREGNANCY HISTORY

Is this your first pregnancy? Yes ☐ No ☐

If no, how many prior pregnancies? _____

At what age did you get your first menstrual period? _____

Please indicate what occurred with prior pregnancies: (indicate #)

Abortion: ____ Miscarriage: ____

Birth: ____ Vaginal delivery: ____ C-Section: ____

Were there any problems or complications with prior pregnancies or births? Yes ☐ No ☐

If yes, please describe: _____

_____

Were any of your other children/pregnancies premature? Yes ☐ No ☐

Were any of your other children multiple births (twins or triplets)? Yes ☐ No ☐

PREGNANCY INFORMATION

What is your due date? _____

What was your age when you became pregnant? _____

What was the date of your last period? _____

How far along was your pregnancy before you realized that you were pregnant? _____

Has your pregnancy been confirmed by testing (other than a home test)? Yes ☐ No ☐
If yes, when and where: _____

Have you ever used birth control ? Yes ☐ No ☐
If yes, what type and duration of use: _____

Were you using birth control when you became pregnant? Yes ☐ No ☐
If yes, please indicate what type: _____

Did you have any food cravings during this pregnancy? Yes ☐ No ☐
If yes, please describe: _____

Within the 30 day period before or after conceiving your baby with the Birth Father, did you have intercourse with anyone else? Yes ☐ No ☐

Are you biologically related to the father of this child? Yes ☐ No ☐
If yes, how? _____

What is the race/ethnicity of your baby? (check **all** that apply)

☐ Caucasian/White ☐ African-American ☐ Hispanic or Latino

☐ American Indian ☐ Asian ☐ Native Hawaiian or other Pacific Islander

☐ Alaskan Native ☐ Unable to Determine ☐ Other_____

If Native American (American Indian) or Alaskan Native, specify name of tribe and degree of Indian blood if known_____

Have you been involved in any accidents during this pregnancy? Yes ☐ No ☐
If yes, please describe in detail: _____

_____

Has anyone hit you, knocked you down or shoved you during this pregnancy? Yes ☐ No ☐
If yes, please describe in detail, including whether you called the police or got medical attention:_____

_____

To your knowledge, were you exposed to lead or mercury during this pregnancy?

Yes ☐ No ☐ If yes, please describe: _____

Have you had excessive bleeding during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had any kidney or bladder infections during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had any operations during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had any convulsions during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had *any* complications during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

If you are currently employed, do you plan to stop working prior to the birth of this child?

Yes ☐ No ☐

LABOR AND DELIVERY INFORMATION

Are you seeing a doctor during this pregnancy? Yes ☐ No ☐

If yes, Doctor's Name/name of practice: _____

Address: _____

Phone w/ area code: _____

If applicable, when did you first see a doctor for prenatal care? _____

How many prenatal visits have you had? _____

How much weight have you gained during pregnancy? _____

Please list all doctors, medical providers, counselors or social workers who have provided treatment or care to you and/or the child (include name, address, and telephone number). Use additional pages if needed

_____

_____

_____

Does your doctor know you are considering adoption? Yes ☐ No ☐

At which hospital will you be delivering?

Name _____

Address: _____

Phone w/ area code: _____

Have you registered with the hospital yet? Yes ☐ No ☐

Are you aware of their policies regarding adoption? Yes ☐ No ☐

Have you spoken with anyone at the hospital about your adoption plan? Yes ☐ No ☐

If yes, please list their name and their position or title _____

_____

TESTS DURING PREGNANCY

Amniocenteses	Yes ☐	No ☐	Date_____	Result_____
Sonogram	Yes ☐	No ☐	Date_____	Result_____
Blood Test	Yes ☐	No ☐	Date_____	Result_____
VDRL Screening	Yes ☐	No ☐	Date_____	Result_____
AIDS Test	Yes ☐	No ☐	Date_____	Result_____
X-Rays	Yes ☐	No ☐	Date_____	Result_____
EKG	Yes ☐	No ☐	Date_____	Result_____
Radiation	Yes ☐	No ☐	Date_____	Result_____
Tuberculosis	Yes ☐	No ☐	Date_____	Result_____
Other tests	Yes ☐	No ☐	Date_____	Result_____

If some or all of the above tests have been completed, please ask your doctor to forward a copy of the results to us. Please ask your doctor to send a letter stating your estimated date of delivery and your general health.

CONDITIONS DURING PREGNANCY OR WITHIN FIVE YEARS BEFORE PREGNANCY

Rubella/Measles	Yes ☐	No ☐	Date_____	Treatment_____
Gonorrhea	Yes ☐	No ☐	Date_____	Treatment_____
Vaginal Warts	Yes ☐	No ☐	Date_____	Treatment_____
Virus	Yes ☐	No ☐	Date_____	Treatment_____
Infections	Yes ☐	No ☐	Date_____	Treatment_____
Chlamydia	Yes ☐	No ☐	Date_____	Treatment_____
Herpes	Yes ☐	No ☐	Date_____	Treatment_____
Cytomegalovirus	Yes ☐	No ☐	Date_____	Treatment_____
Parvovirus	Yes ☐	No ☐	Date_____	Treatment_____
Syphillis	Yes ☐	No ☐	Date_____	Treatment_____
Toxoplasmosis	Yes ☐	No ☐	Date_____	Treatment_____
Varciella	Yes ☐	No ☐	Date_____	Treatment_____
Cancer Therapy	Yes ☐	No ☐	Date_____	Treatment_____
HIV/AIDS	Yes ☐	No ☐	Date_____	Treatment_____
Allergies	Yes ☐	No ☐	Date_____	Treatment_____
Hepatitus	Yes ☐	No ☐	Date_____	Treatment_____

MEDICAID INFORMATION

Do you have Medicaid? Yes ☐ No ☐

If no, are you eligible and willing to apply? Yes ☐ No ☐

If yes, date applied and Medicaid number? _____

What state/county is your Medicaid issued through? _____

Date benefits begin: _____

INSURANCE INFORMATION

Do you have medical insurance coverage? Yes ☐ No ☐

If yes, Company name: _____

Address: _____

Phone Number: _____

Policy Number: _____

If you know, what percentage of medical costs will your insurance company cover for this pregnancy? _____

MEDICATION & DRUG/ALCOHOL USAGE

*Please be very specific as to any drugs or alcohol used during your pregnancy or in the last 5 years, including the frequency of usage. This information is very important for the prediction of your child's health. This information will be passed along to the adoptive family and to the child's pediatrician. Place an '**X**' in the applicable boxes and leave* blank all other boxes.

Please be specific about any prescription drugs used or prescribed during your pregnancy:

Name of drug: _____
Prescribed for: _____
Length used: _____

Name of drug: _____
Prescribed for: _____
Length used: _____

Name of drug: _____
Prescribed for: _____
Length used: _____

Name of drug: _____
Prescribed for: _____
Length used: _____

Name of drug: _____
Prescribed for: _____
Length used: _____

DRUG & ALCOHOL USAGE	Not used in 5 years prior to pregnancy	Never Used During Pregnancy	Used occasionally (1-5 times) during pregnancy	Used monthly during pregnancy	Used weekly during pregnancy	Used daily during pregnancy
Cigarettes						
Alcohol						
Marijuana						
Cocaine/Crack						
Amphetamines, incl. Meth						
Heroin						
Ecstasy						
Methadone						
LSD						
Stimulants						
Depressants						
Diet Pills						
Tranquilizers						
Anti-Convulsants						
Medication for Diabetes						
Heart/Blood Pressure meds						
Pain Relievers, incl aspirin						
Medicine for Convulsions						
Medicine for Nausea						
Antibiotics						
Antihistimines						
Hormones						
Cortisone (ATCH, etc.)						
Medication for Cancer						
Thalidomides						
Nose Drops or Spray						
Barbituates						
Caffeine (coffee, tea, etc.)						

DRUG & ALCOHOL USAGE	Not used in 5 years prior to pregnancy	Never Used During Pregnancy	Used occasionally (1-5 times) during pregnancy	Used monthly during pregnancy	Used weekly during pregnancy	Used daily during pregnancy
Aminopterin						
ACE Inhibitors						
Busulfan						
Sleeping pills						
Carbanazepine						
Cholorobiphenyls						
Cyclophosphamide						
Diethylstilbestrol						
Etretinate						
Iodine						
Acutane						
Lithium						
Phenobarbital						
Phenytoin						
Propylthiouracil						
Prostaglandin						
Tetracycline						
Valproic Acid						
Warfarin						
Steroids						
Fertility drugs						
PCP (Angel Dust)						
Vitamin A						
Vitamin D						
Vitamin E						

Did/do either of your parent(s) have a problem with drug or alcohol abuse? Yes ☐ No ☐

If yes, please explain: _____

Does/did this child's father have a problem with drug or alcohol abuse? Yes ☐ No ☐

If yes, please explain: _____

The above information is true to the best of my knowledge and belief:

Signed _____

Date _____