Birth Father's Medical History

*Print Name:*_____

BIRTH FATHER'S PHYSICAL CHARACTERISTICS & PREFERENCES

Eye Color: _____

Height: _____ Weight: _____ Body Build: _____

Complexion: ☐ Fair ☐ Olive ☐ Tan ☐ Dark ☐ Other _____

Is your skin sensitive? Yes ☐ No ☐

Hair Color: ☐ Blonde ☐ Brown ☐ Red ☐ Gray ☐Other: _____

Hair Texture ☐ Straight ☐ Naturally Curly ☐ Wavy ☐ Fine ☐ Thick

Do you have any allergic reaction to anything? Yes ☐ No ☐
If yes, specify_____

Did you ever wear braces for your teeth, or told that you should? Yes ☐ No ☐

Do you wear glasses or contact lenses? Yes ☐ No ☐
If yes, what age did you start wearing them? _____

Are you right-handed or left-handed? Right ☐ Left ☐

Blood Type: _____ RH Factor: _____

HEALTH HISTORY OF BIRTH FATHER

Place an "X" if the listed medical condition exists in your medical history or if any relatives or other family members have/had any of the conditions. If one of your relative's deaths was the result of a particular medical condition, note it on the comments section to the right of the condition and write the age at which they died. *Use additional pages if needed*

Medical Condition	You	Your mother	Your father	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please Indicate and other pages
HIV/AIDS (medications prescribed)						
Bone Cancer (be specific, age at onset)						
Prostrate Cancer (be specific, age at onset)						
Lung Cancer (be specific, age at onset)						
Melanoma/ Skin Cancer (be specific, age at onset)						
Stomach Cancer (be specific, age at onset)						
Liver Cancer (be specific, age at onset)						
Pancreatic Cancer (be specific, age at onset)						
Other cancer (specify)						
Diabetes (insulin dependent? Adult or juvenile?)						
Retardation: mental or physical (be specific)						
Down's Syndrome						
Turner's Syndrome						
Hydrocephalus (water on the brain)						
Microencephalus						
Other developmental disorders (be specific)						

Medical Condition	You	Your mother	Your father	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages
Diagnosed schizophrenia						
Obsessive Compulsive Disorder						
Serious depression						
Repeated infections						
Lymphoma						
Neuro Tube Defect						
Fetal alcohol syndrome or effect						
Trisomy						
Ambiguous genitalia						
Osteoporosis						
Colitis						
Malnutrition						
Apnea Monitor						
Bed wetting						
Wilson's Disease						
Gout						
Diagnosed manic depressive						
Sickle cell anemia or trait						
Cystic fibrosis						
Leukemia						
Club foot or any orthopedic problem						
Harelip (Cleft lip) or Cleft palate						
Cerebral Palsy						
Muscular dystrophy						
Dwarfism						
Spina Bifida						
Congenital heart defect (be specific)						
Tuberculosis						

Medical Condition	**You**	**Your mother**	**Your father**	**Your brother(s) or sister(s)**	**Your children**	**Indicate cause, treatment, medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages**
Thyroid Disorder						
Hay fever						
Food allergy(s)						
Drug allergy(s) (name of drug(s))						
Other allergy(s) (be specific)						
Farsighted						
Nearsighted						
Astigmatism (inability to focus)						
Different color eyes						
Night blindness or color blindness						
Glaucoma						
Detached retina Blindness (cause of blindness)						
Cataracts or other visual problems (be specific)						
Strabismus (crosseye)						
Sinus or nasal problems						
Ear infections						
Deafness						
Other ear problems						
Teeth problems (excessive cavities, too many or too few teeth)						
Gum disease						
Hypertension (high blood pressure)						
Heart murmurs						
Mitral valve prolapse						
Heart attack(coronary)						

Medical Condition	You	Your mother	Your father	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages
Hemophilia						
Stroke						
Congestive Heart Defect						
Anemia						
Cooley's anemia (Thalassemia)						
Heart Surgery (date of surgery)						
Blood disorder						
Alzheimer's Disease						
Eczema, acne or other skin condition						
Hives						
Atherosclerosis						
Mononucleosis						
Hepatitis (specify type)						
Jaundice or yellow skin						
Cirrhosis						
Other liver problems						
Scoliosis (curvature of spine) or hunchback						
Back problems (pinched nerve, slipped disc)						
Arthritis						
Lupus						
Rheumatic Fever						
Neurofibromatosis						

Medical Condition	You	Your mother	Your father	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, specific medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages
Atrial Fibrillation						
Irregular/abnormal heart beat						
Any other heart or circulatory problems (be specific)						
Asthma						
Chronic Bronchitis						
Sudden Infant Death Syndrome (SIDS)						
Pneumonia						
Reactive airway disease						
Angina						
Other respiratory disorders						
Ulcers (be specific)						
Colitis						
Gall bladder problem						
High Cholesterol						
Obesity						
Anorexia/Bulimia						
Suicide or attempted suicide						
Other Digestive Disorders (be specific)						
Bladder Problems						
Kidney failure/transplant or problems						
Kidney stones						
Speech problems						
Learning disability (specify diagnosis)						
Dyslexia						
Autism						
Hyperactivity ADHD/ADD						

Medical Condition	You	Your mother	Your father	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please indicate and use other pages
Eczema or other skin conditions						
Alcoholism or heavy drinking						
Drug usage (list specific drugs)						
Other mental or behavioral disorders (be specific)						
Multiple sclerosis						
Lou Gehrig's disease						
Seizures or convulsions (medications prescribed)						
Huntington's disease						
Parkinson's Disease						
Epilepsy						
Tourette's syndrome						
Crohn's Disease						
Lyme Disease						
Migraine headaches						
Other nervous system disorders (be specific)						
Arthritis						
Hodgkin's disease						
Cysts, lumps, or growths						
Tumors						
Endometriosis						
Emphysema						
Chromosone abnormality						
Tay-Sachs Disease						
Birthmarks (unusual size or shape)						
Pyloric stenosis (projectile vomiting)						

MEDICAL TESTS TAKEN IN THE LAST FIVE YEARS

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 IN THE LAST FIVE YEARS

Rubella/Measles	Yes ☐	No ☐	Date_____	Treatment_____
Gonorrhea	Yes ☐	No ☐	Date_____	Treatment_____
Virus	Yes ☐	No ☐	Date_____	Treatment_____
Infections	Yes ☐	No ☐	Date_____	Treatment_____
STD	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_____
Hepatitis	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 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: _____

DRUG & ALCOHOL USAGE	Not used in 5 years	Not used in the last year	Used occasionally (1-5 times) during the last year	Used monthly in the last year	Used weekly In the last year	Used daily In the last year
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	Never Used In the last year	Used occasionally (1-5 times) in the last year	Used monthly in the last year	Used weekly In the last year	Used daily in the last year
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 mother have a problem with drug or alcohol abuse? Yes ☐ No ☐

If yes, please explain: _____

Have you ever gone to a psychologist, psychiatrist, clinical social worker, mental health or behavioral health therapist for any emotional or psychological or behavioral problems you may have had? Yes ☐ No ☐ If yes:

Date(s) and reasons for treatment_____

_____

_____

Name and location of therapist and/or agency that provided treatment:

_____

_____

_____

Indicate medications prescribed during treatment

_____

_____

Reason for discontinuance if no longer in treatment

_____

_____

Please list any other medical issues or information about you, your family or the birth father or his family that were not covered in the information above:

_____

_____

_____

Would you be willing to be contacted in the future if a health problem arises for the child which requires either additional health history, transfusion or an organ transplant? Yes ☐ No ☐

Comments_____

_____

_____

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

_____

Signature

_____

Date