Birth Mother's Medical History

*Print Name:*_____

BIRTH MOTHER'S PHYSICAL CHARACTERISTICS & PREFERENCES

Eye Color: _____

Height: _____ Weight (before pregnancy): _____ Body Build: _____

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

Is your skin sensitive? Yes ☐ No ☐

Hair Color: ☐ Blonde ☐ Brunette ☐ Red ☐ Other: _____

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

Hair Style preference ☐ Long ☐ Short

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 ☐

At what age did you start menstruation? _____

Did you have any problems with it, such as cramping or headaches? Yes ☐ No ☐

If yes, describe _____

Blood Type: _____ RH Factor: _____

HEALTH HISTORY OF BIRTH MOTHER

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)						
Breast Cancer (be specific, age at onset)						
Cervical Cancer (be specific, age at onset)						
Uterine Cancer (be specific, age at onset)						
Ovarian Cancer (be specific, age at onset)						
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)						
Brian tumor						
Other cancer (specify)						
Diabetes (insulin dependent? Adult or juvenile?)						

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
Retardation: mental or physical (be specific)						
Down's Syndrome						
Turner's Syndrome						
Hydrocephalus (water on the brain)						
Microencephalus						
Other developmental disorders (be specific)						
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						
Gynecological problems (specify)						
Wilson's Disease						
Gout						
Diagnosed manic depressive (medications prescribed)						
Sickle cell anemia or trait						
Cystic fibrosis						
Leukemia						
Club foot or any orthopedic problem						

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
Harelip (Cleft lip) or Cleft palate						
Cerebral Palsy						
Muscular dystrophy						
Dwarfism						
Spina Bifida						
Congenital heart defect (be specific)						
Tuberculosis						
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 (cause of deafness)						
Other ear problems						

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
Teeth problems (excessive cavities, too many or too few teeth)						
Gum disease						
Hypertension (high blood pressure)						
Heart murmurs						
Mitral valve prolapse						
Heart attack (coronary)						
Hemophilia (free bleeder)						
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						

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Atrial Fibrillation						
Irregular/abnormal heart beat						
Any other heart or circulatory problems (be specific)						
Asthma (medications prescribed)						
Chronic Bronchitis						
Sudden Infant Death Syndrome (SIDS)						
Pneumonia						
Reactive airway disease						
Angina						
Other respiratory disorders						
Ulcers (be specific)						
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						
Endometriosis						
Menstrual problems						
Problem pregnancies						
Emphysema						
Chromosone abnormality						
Tay-Sachs Disease						

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Birthmarks (unusual size or shape)						
Pyloric stenosis (projectile vomiting)						
Neurofibromatosis						

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 accurate to the best of my knowledge

_____
Signature

_____
Print Name

_____
Date