



## Medical and Social History Report for Adoption Cover Sheet

Pursuant to Section 7504-1.1 of Title 10 of the Oklahoma Statutes (10 O.S. § 7504-1.1), except as otherwise provided by the Oklahoma Adoption Code, before placing a minor for adoption, a complete written medical and social history report of the minor to be adopted shall be completed by: (1) the Oklahoma Department of Human Services (OKDHS); (2) a licensed child-placing agency; (3) the attorney representing the adoptive parent in the adoption proceedings; or (4) when the adoptive parent is not represented by an attorney in a direct placement adoption, the person placing the minor for adoption.

This cover sheet is removed prior to disclosure of the report to the:

1. prospective adoptive or adoptive parent;
2. legal guardian of the adopted person;
3. adopted person;
4. adopted person's direct descendants;
5. parents or guardians of the adopted person's descendants; or
6. person to whom disclosure is permitted pursuant to the Oklahoma Adoption Code.

<b>Court case number</b>	County of court proceeding
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<b>Child's name</b>	Date of birth
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<b>Birth mother's name</b>	Date of birth	Social Security number	
Permanent mailing address	City	State	Zip

<b>Birth father's name</b>	Date of birth	Social Security number	
Permanent mailing address	City	State	Zip

<b>Name of person compiling this report</b>	Relationship to the child		
Address	City	State	Zip

## Form 04AN347E, Medical and Social History Report for Adoption Instructions

Form 04AN347E is completed to record the medical and social history of the child placed for adoption.

The cover sheet identifies the child and birth parents and is attached to the report filed with the court and may be retained by Oklahoma Department of Human Services (OKDHS), a licensed child-placing agency, or an attorney representing a party in the adoption proceeding.

Form 04AN347E requests information required by 10 O.S. § 7504-1.1 subsections B and C that is reasonably available from each biological parent, from any person who has had legal or physical custody of the minor, and from any other relative, or other person or entity who can provide information that cannot otherwise reasonably be obtained from the biological parents or a person who has had legal or physical custody of the minor and includes:

1. a copy of all medical, dental, and psychological records of the minor obtained from anyone who has provided medical, dental, or psychological services to the minor; and
2. a copy of all of the minor's educational records.

Stepparent adoption: When the petitioner for the adoption of a minor is a stepparent of the minor and the minor will remain in the legal custody of one biological parent and the stepparent following the adoption, only the medical and social history of the parent whose parental rights are sought to be terminated and that parent's biological relatives is compiled in the medical and social history report.

Relative adoption: When the petitioner for the adoption of a minor is related to the child, only the medical and social history of the parent who is not related to the petitioner and the biological relatives of such parent is completed in the medical and social history report.

Notice to biological parent, adoptive parent, or  
any person who submitted information for this report

*Pursuant to 10 O.S. § 7504-1.1 E.2, OKDHS, the licensed child-placing agency, attorney for the adoptive parent, or person who prepares the medical and social history report shall advise the biological parents, any other persons who submitted information for the report and the adoptive parent that additional information about the adopted person, the biological parents, and the adopted person's genetic history that becomes available may be submitted to OKDHS, the licensed child-placing agency, attorney, or person who prepared the report or if the location is known to them, to the clerk of the court that issues the decree of adoption. Nothing in this section shall require that the location of the court in which the adoption action is filed be revealed to the biological parents, biological relatives or other persons who submitted information for the report, if the location is not otherwise known to them.*

When feasible, the biological parents, legal or physical custodians of the minor or other biological relatives are assisted in providing information for the medical and social history report by trained professionals employed by the: (1) OKDHS; (2) licensed child-placing agency; or (3) attorney for the adoptive parent.

The court may request that a biological parent, a present or former legal or physical custodian of the minor, a biological relative, a school, or a medical, dental, or psychological care provider for the child supply the information or records required by 10 O.S. 7504-1.1.

When printing document sections for handwritten completion print:

- pages 5 - 24 for Section 1. Child's Medical and Social History;
- pages 25 - 45 for Section 2. Mother's Medical and Social History; and
- pages 47 - 67 for Section 3. Father's Medical and Social History.

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## Section 1: Child's Medical and Social History

### 1. Biological mother's health during pregnancy

In what month of the pregnancy of the child placed for adoption did the birth mother first see a health care provider?

- |  |  |
|--|--|
| <input type="checkbox"/> first<br><input type="checkbox"/> second<br><input type="checkbox"/> third<br><input type="checkbox"/> fourth<br><input type="checkbox"/> fifth | <input type="checkbox"/> sixth<br><input type="checkbox"/> seventh<br><input type="checkbox"/> eighth<br><input type="checkbox"/> ninth<br><input type="checkbox"/> no prenatal care |
|--|--|

During the pregnancy with this child, did the birth mother have or was she exposed to:	Yes	No	Do not know	Month during pregnancy
fever of 102 degrees or higher for more than 48 hours? If yes, diagnosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
rashes? If yes, diagnosis, site, or kind:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
infection? If yes, diagnosis, site, or kind:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
x-rays or radiation therapy? If yes, diagnosis, site, or kind:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
toxic substances, fumes, exposure to any occupational hazard that could affect the child? If yes, diagnosis, site, or kind:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
sexually transmitted disease(s)? If yes, diagnosis, site, or kind:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS)? If yes, explain:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

During the pregnancy with this child, did the birth mother have or was she exposed to:	Yes	No	Do not know	Month during pregnancy
gestational diabetes? If yes, diagnosis:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
measles or rubella? If yes, diagnosis, site, or kind:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
mumps or chicken pox? If yes, diagnosis, site, or kind:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
high blood pressure? If yes, was it a pre-existing condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
preeclampsia, increased blood pressure, swelling, or protein in urine? If yes, diagnosis or other related information:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
eclampsia or preeclampsia symptoms with seizures? If yes, diagnosis or other related information:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
seizures without eclampsia? If yes, diagnosis and kind:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
other diseases or injuries during pregnancy? If yes, diagnosis, site, or kind:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
alcohol, beer, or wine? If yes, how much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
cigarettes or other tobacco? If yes, how many/much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
cocaine? If yes, how much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

During the pregnancy with this child, did the birth mother have or was she exposed to:	Yes	No	Do not know	Month during pregnancy
crack cocaine? If yes, how much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
heroin? If yes, how much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
methadone? If yes, how much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LSD or acid? If yes, how much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
paint or glue sniffing? If yes, how much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
marijuana, also known as pot? If yes, how much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
amphetamines, also known as crank or uppers? If yes, how much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
methamphetamine? If yes, how much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
barbiturates, also known as downers? If yes, how much per week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
other abused drugs? If yes, what drug and how much per week:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
prescription medication(s)? If yes, list name(s) of prescriptions:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

During the pregnancy with this child, did the birth mother have or was she exposed to:	Yes	No	Do not know	Month during pregnancy
over-the-counter medication(s)? If yes, list name(s) of medication(s):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

## 2. Child's birth

Child's gender <input type="checkbox"/> male <input type="checkbox"/> female	Date of birth	Time of birth	Hospital or location of birth	
City of birth	State of birth		County of birth	

Describe the birth mother's health at the time of delivery.

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How long was the mother's labor? \_\_\_\_\_

Was the delivery  vaginal or  cesarean? If cesarean, why?

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Was labor induced?  Yes  No If yes, why?

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Were there any problems during this delivery?  Yes  No  Don't know

If yes, explain. \_\_\_\_\_

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The baby was born:  head first  breach  don't know.

Were health problems or birth defects noted at birth?  Yes  No  Don't know

If yes, explain. \_\_\_\_\_

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Were problems noted after birth?  Yes  No  Don't know  
 If yes, explain and indicate the child's age at the time the problem was noted.

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Baby was born:  at term  
 premature at \_\_\_\_\_ weeks.  
 postmature at \_\_\_\_\_ weeks.

Birth weight pounds                      ounces	Birth length inches	Head circumference
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Apgar score at: one minute \_\_\_\_\_ and five minutes \_\_\_\_\_  don't know.

Baby's blood type:

- |                             |                                      |
|-----------------------------|--------------------------------------|
| <input type="checkbox"/> A  | <input type="checkbox"/> Rh positive |
| <input type="checkbox"/> B  | <input type="checkbox"/> Rh negative |
| <input type="checkbox"/> AB | <input type="checkbox"/> Don't know  |
| <input type="checkbox"/> O  |                                      |

Were any of the newborn screening tests abnormal?  Yes  No  Don't know

If yes, describe. \_\_\_\_\_

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The child born to parents who are related by blood has a greater chance of health problems. Are the birth parents:

- |   |  |
|---|--|
| <input type="checkbox"/> father and daughter          | <input type="checkbox"/> uncle and niece |
| <input type="checkbox"/> mother and son               | <input type="checkbox"/> aunt and nephew |
| <input type="checkbox"/> brother and sister           | <input type="checkbox"/> first cousins   |
| <input type="checkbox"/> half-brother and half-sister | <input type="checkbox"/> unrelated       |

### 3. Child's current primary care physician

Child's current or most recent primary care physician		Physician's number	
Physician's address	City	State	Zip

#### 4. Child's illnesses, diseases, and congenital or birth defects

Has the child had or does the child have:	Yes	If yes, age	No	Do not know
measles	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
German measles	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
chicken pox	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
mumps	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
scarlet fever	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
tuberculosis	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
appendicitis	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
hepatitis	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Reye syndrome	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
arthritis	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
epilepsy or seizures	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
hearing loss	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
cerebral palsy	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
sickle cell anemia	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
whooping cough	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
pneumonia	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
meningitis	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
encephalitis	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
anemia	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
cystic fibrosis	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
diabetes	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
failure to thrive	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Has the child had or does the child have:	Yes	If yes, age	No	Do not know
heart defect	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
mental retardation	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
vision difficulties	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
kidney disease	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
congenital or birth defects	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Explain the duration, severity, and treatment provided for any illness, condition, or disease marked yes above.

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List the child's other diseases or illnesses that required medical treatment or hospitalization including: (1) chronic or recurring illnesses such as, ear infections, colic, or digestive ailments; and (2) remarks regarding the duration and severity of the illness or disease and the treatment received.

Type of illness or disease	Date	Remarks

## 5. Child's allergies

Describe the child's: (1) allergies to things such as food, medication, insects, or environmental conditions; (2) symptoms of the allergic reaction; (3) duration of the reaction; and (4) treatment for the allergic condition.

Allergy	Symptoms	Duration	Treatment

## 6. Child's traumas, accidents, or injuries

Describe the traumas, accidents, or injuries the child has suffered including the severity and treatment received for each incident.

Trauma, accident, or injury	Severity	Treatment received

## 7. Child's surgeries

Describe the child's surgeries including the: (1) type; (2) date; (3) medical facility; and (4) purpose of the surgery.

Type of surgery	Date of surgery	Medical facility	Purpose of surgery

Are copies of the child's medical records from anyone who has examined the child attached per 10 O.S. § 7504-1.1?  Yes  No

**8. Child's physical development**

Is or was the child's rate of growth and physical development:

within normal limits; or  delayed?

If the child's growth and physical development is outside normal limits, explain:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Child's current height: \_\_\_\_\_

Child's current weight: \_\_\_\_\_

Date measured and weighed: \_\_\_\_\_

Child's current head circumference, if child is less than two years of age: \_\_\_\_\_

**9. Child's immunization record**

Is the child's current immunization record attached?  Yes  No

If no, the immunization record is located at: \_\_\_\_\_

Has the child displayed any abnormal reactions to vaccines?  Yes  No  Don't know

If yes, explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**10. Child's dental health**

Has the child received regular dental care?  Yes  No  Don't know

If yes, how often? \_\_\_\_\_

Date of last dental visit? \_\_\_\_\_

Dentist's name and office location: \_\_\_\_\_

Describe: (1) any dental problems and diseases the child has suffered; (2) the date of onset; (3) duration; (4) and dental treatment provided.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are copies of the child's dental records from anyone who has provided dental services to the child attached per 10 O.S. § 7504-1.1?  Yes  No

## 11. Child's psychological and behavioral health

Has the child ever been examined, evaluated, diagnosed, or treated for any psychological diseases, conditions, or problems?  Yes  No  Don't know

If yes, list the: (1) date; (2) name and type of professional who conducted the examination or evaluation or who made the diagnosis; (3) reason for any examination or evaluation; (4) diagnosis and treatment provided; and (5) testing and medication prescribed and the reasons. Attach additional sheets when necessary to provide additional details.

	Date	Service provider and location	Reason for the examination or evaluation
1.			
Diagnosis and treatment(s) provided:			
Testing or medications prescribed and reasons:			

	Date	Service provider and location	Reason for the examination or evaluation
2.			
Diagnosis and treatment(s) provided:			
Testing or medications prescribed and reasons:			

	Date	Service provider and location	Reason for the examination or evaluation
3.			
Diagnosis and treatment(s) provided:			
Testing or medications prescribed and reasons:			

Are copies of the child's psychological or behavioral health records attached as required by 10 O.S. 7504-1.1?  Yes  No

## 12. Child's developmental history

List the age in months at which the child performed the listed activities.

Activity	Age in months	Activity	Age in months
smile		use crayons	
roll front to back		use two word sentences	
sit unsupported		read	
crawl		count to ten	
stand alone		correctly identify four colors	
walk alone		toilet train (bladder)	
say two to three words		toilet train (bowels)	
point to body parts			

Has the child's attainment of developmental milestones been delayed?  Yes  No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

Has the child received early intervention services such as SoonerStart, speech therapy, or physical therapy?  Yes  No

If yes, explain: \_\_\_\_\_

\_\_\_\_\_

## 13. Child's behavior

Has the child displayed:	Yes	If yes, age of onset	No	Do not know
violence to family members	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
violence to other children	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
violence to other adults	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
sexual abuse of others	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
sexual acting out	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Has the child displayed:	Yes	If yes, age of onset	No	Do not know
unusual aggression	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
abuse to animals	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
excessive lying for the child's age	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
threats of violence	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
self-mutilation	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
threats of suicide	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
suicide attempts	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
fire setting	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
property destruction	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
explosive temper	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
lack of control	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
difficulty bonding	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

Explain in detail any yes answers, including the duration of the behaviors, the circumstances, and the outcomes of the behaviors. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the child been convicted of a crime or adjudicated as a delinquent?  Yes  No

If yes, describe: (1) the nature of each offense; (2) the child's age at the time of the offense; (3) the circumstances of the offense; (4) the conviction or adjudication; and (5) the punishment imposed or other outcome of the adjudication.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## 14. Child's placement history

Chronologically list the child's placements since birth including the: (1) relation of the person with whom the child lived; (2) reasons for the change of caregiver or placement; and (3) the child's relationship with the caregiver. Attach additional sheets as necessary.

	Dates of placement	Caregiver's relation to child such as mother or paternal aunt	Reason for change of caregiver or placement
1	Birth to		
Describe the child's relationship with this caregiver.			

	Dates of placement	Caregiver's relation to child such as mother or paternal aunt	Reason for change of caregiver or placement
2	to		
Describe the child's relationship with this caregiver.			

	Dates of placement	Caregiver's relation to child such as mother or paternal aunt	Reason for change of caregiver or placement
3	to		
Describe the child's relationship with this caregiver.			

	Dates of placement	Caregiver's relation to child such as mother or paternal aunt	Reason for change of caregiver or placement
4	to		
Describe the child's relationship with this caregiver.			

	Dates of placement	Caregiver's relation to child such as mother or paternal aunt	Reason for change of caregiver or placement
5	to		
Describe the child's relationship with this caregiver.			

## 15. Child's siblings

List the child's siblings by first name only, the sibling's date of birth (DOB), the sibling's current placement, and describe the child's relationship with each brother or sister including whether visitation occurs. Attach additional sheets if necessary.

1.	Sibling's first name	DOB	Gender	Sibling's current placement
			<input type="checkbox"/> male <input type="checkbox"/> female	

Describe the child's relationship with this sibling, including whether visitation occurs.

2.	Sibling's first name	DOB	Gender	Sibling's current placement
			<input type="checkbox"/> male <input type="checkbox"/> female	

Describe the child's relationship with this sibling, including whether visitation occurs.

3.	Sibling's first name	DOB	Gender	Sibling's current placement
			<input type="checkbox"/> male <input type="checkbox"/> female	

Describe the child's relationship with this sibling, including whether visitation occurs.

4.	Sibling's first name	DOB	Gender	Sibling's current placement
			<input type="checkbox"/> male <input type="checkbox"/> female	

Describe the child's relationship with this sibling, including whether visitation occurs.

5.	Sibling's first name	DOB	Gender	Sibling's current placement
			<input type="checkbox"/> male <input type="checkbox"/> female	

Describe the child's relationship with this sibling, including whether visitation occurs.

## 16. Child's relationships with extended family

List birth or extended family members the child currently visits or with whom the child has had a past or current relationship.

Name	Relationship to child	Comments regarding the relationship

List other non-relative persons with whom the child has lived or had a past or current significant relationship.

Name	Relationship to child	Comments regarding the relationship

## 17. Child's abuse or neglect history

Chronologically document any physical, sexual, or emotional abuse or neglect incidents suffered by the child including the: (1) incident date; (2) allegations; (3) alleged perpetrator; (4) injuries; and (5) child's reaction. Attach additional sheets if necessary.

Incident date	Allegations and alleged perpetrator
Injuries: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, describe:	
Describe child's reaction to the incident:	

Incident date	Allegations and alleged perpetrator
Injuries: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, describe:	

Describe child's reaction to the incident:

Incident date	Allegations and alleged perpetrator

Injuries:  Yes  No  
If yes, describe:

Describe child's reaction to the incident:

Has the child witnessed any physical, sexual, or emotional abuse to members of the child's family, household, or others?  Yes  No

If yes, describe including: (1) the date or time period; (2) the nature of the abuse, circumstances, relationship of the abuser and victim to the child; (3) frequency; and (4) child's reaction.

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Has there been a criminal conviction, judicial order terminating parental rights, or other proceeding in which a birth parent was alleged to have abused, neglected, abandoned, or otherwise mistreated the child, the child's sibling(s), or the other biological parent?  Yes  No

If yes, describe including: (1) the date of the proceeding; (2) the nature and circumstances surrounding the allegations; (3) the victim; and (4) the outcome of the judicial proceeding.

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## 18. Child's personal preferences and culture

Describe the child's personal preferences such as hobbies, interests, favorite foods, music, activities, sports, outings, toys, and pets.

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Describe the child's strengths.

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Describe the child's culture, including: (1) the child's cultural background and whether the child identifies with his or her cultural or ethnic group.

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What languages does the child speak and understand?

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What are the child's most important traditions, values, and beliefs?

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What is the child's religious or spiritual background?

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What is the child's favorite holiday?

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How is the child's birthday celebrated?

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## 19. Child's educational history

The child is not of school age.

Child's current grade level: \_\_\_\_\_

Describe the child's educational history, from preschool through the present grade, including: (1) grade level; (2) name of school attended; (3) city and state; and (4) academic performance.

Grade(s)	School name	City and state	Academic performance

Is the child in special education?  Yes  No

If yes, (1) detail the results of all testing and recommendations related to the determination for special education; and (2) explain when and why the determination was made for special education.

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Is further educational testing necessary?  Yes  No

If yes, explain.

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Does the child have an Individual Education Plan (IEP)?  Yes  No

If yes, summarize the IEP.

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Document the child's most recent report card grades.

Date	Class name or subject	Grade	Comments

Detail the child's academic strengths and weaknesses, including: (1) what the child likes most and least about school; and (2) the child's school activities.

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Are the child's educational records attached as required by 10 O.S. § 7504-1.1?  Yes  No

## 20. Child's eligibility for governmental benefits

Is the child eligible for or receiving state or federal benefits including:

State or federal program		Comments regarding eligibility or potential eligibility
Developmental Disabilities Services (DDSD)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Supplemental Security Income (SSI)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Supplemental Security Survivor benefits (SSA)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Medicaid	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
Adoption assistance	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	
List other state or federal benefits the child receives	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> don't know	

The information contained in Section 1. Child's medical and social history was provided by:

birth mother

birth father

other, specify relationship to birth mother: \_\_\_\_\_

other, specify relationship to birth mother: \_\_\_\_\_

other, specify relationship to birth mother: \_\_\_\_\_

This space intentionally left blank



## Section 2: Birth Mother's Medical and Social History

### 1. Birth mother's general information

Birth mother's date of birth	Place of birth	Birth mother's nationality:
The birth mother is: <input type="checkbox"/> living <input type="checkbox"/> deceased If deceased, cause of and age at death:		Race or ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian-American <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multiethnic, specify:

### 2. Tribal information

Is the birth mother a member of a Native American tribe?  Yes  No

Mother's tribe	CDIB number	Is mother an enrolled tribal member? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Mother's tribal enrollment number		

Is the child placed for adoption a member of a Native American tribe?  Yes  No

Child's tribe	CDIB number	Is the child an enrolled tribal member? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Child's tribal enrollment number		

### 3. Birth mother's physical characteristics

Birth mother's height	Unusual features or birthmarks	
Weight	Eye color	The birth mother is: <input type="checkbox"/> right-handed <input type="checkbox"/> left-handed
Natural hair color	Body build	Skin shade <input type="checkbox"/> Light <input type="checkbox"/> medium <input type="checkbox"/> dark

### 4. Birth mother's childhood history

Briefly describe the birth mother's childhood history.

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## 5. Birth mother's siblings

How many full or half-brothers does the birth mother have? \_\_\_\_\_

How many full or half-sisters does the birth mother have? \_\_\_\_\_

Describe each sibling. Attach additional sheets, if necessary.

Birth mother's sibling	Birth year	Comments about the relationship between birth mother and her sibling	Relative's physical description
<input type="checkbox"/> male <input type="checkbox"/> female			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:
<input type="checkbox"/> living <input type="checkbox"/> deceased If deceased, age at death: _____ ; and cause of death:  Describe any significant health, physical, mental, or learning problems, if any, including age at onset. 1. 2. 3. 4.			

Birth mother's sibling	Birth year	Comments about the relationship between birth mother and her sibling	Relative's physical description
<input type="checkbox"/> male <input type="checkbox"/> female			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:
<input type="checkbox"/> living <input type="checkbox"/> deceased If deceased, age at death: _____ ; and cause of death:  Describe any significant health, physical, mental, or learning problems, if any, including age at onset. 1. 2. 3. 4.			

Birth mother's sibling	Birth year	Comments about the relationship between birth mother and her sibling	Relative's physical description
<input type="checkbox"/> male <input type="checkbox"/> female			height: _____ hair color: _____ weight: _____ eye color: _____ other characteristics:

living    deceased  
If deceased, age at death: \_\_\_\_\_ ; and cause of death: \_\_\_\_\_  
  
Describe any significant health, physical, mental, or learning problems, if any, including age at onset.  
1.  
2.  
3.  
4.

Birth mother's sibling	Birth year	Comments about the relationship between birth mother and her sibling	Relative's physical description
<input type="checkbox"/> male <input type="checkbox"/> female			height: _____ hair color: _____ weight: _____ eye color: _____ other characteristics:

living    deceased  
If deceased, age at death: \_\_\_\_\_ ; and cause of death: \_\_\_\_\_  
  
Describe any significant health, physical, mental, or learning problems, if any, including age at onset.  
1.  
2.  
3.  
4.

List or describe any of the birth mother's sibling's noteworthy accomplishments.

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## 6. Birth mother's parents and grandparents

Describe the mother's relationship with each relative and complete the questions regarding the relative. Attach additional sheets as necessary.

Relative	Birth year	Comments about the relationship between birth mother and relative	Relative's physical description
<b>Birth mother's mother</b>			height: _____ hair color: _____ weight: _____ eye color: _____ other characteristics:

living  deceased

If deceased, age at death: \_\_\_\_\_ ; and cause of death:

Describe any significant health, physical, mental, or learning problems, if any, including age at onset.

1.

2.

3.

4.

Relative's highest level of education?

Describe the relative's religious or spiritual background.

Describe the relative's talents, hobbies, and special interests.

Has the relative been physically or sexually abused?

Yes  No

Has the relative been in a relationship that involved domestic violence?

Yes  No

If yes, describe any significant emotional or behavioral history that resulted due to the relative's victimization.

Describe the relative's occupation and employment history.

Relative	Birth year	Comments about the relationship between birth mother and relative	Relative's physical description
<b>Birth mother's father</b>			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:

living  deceased

If deceased, age at death: \_\_\_\_\_ ; and cause of death:

Describe any significant health, physical, mental, or learning problems, if any, including age at onset.

1.

2.

3.

4.

Relative's highest level of education?

Describe the relative's religious or spiritual background.

Describe the relative's talents, hobbies, and special interests.

Has the relative been physically or sexually abused?

Yes  No

Has the relative been in a relationship that involved domestic violence?

Yes  No

If yes, describe any significant emotional or behavioral history that resulted due to the relative's victimization.

Describe the relative's occupation and employment history.

List or describe the birth mother's parents' noteworthy accomplishments.

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Relative	Birth year	Comments about the relationship between birth mother and relative	Relative's physical description
<b>Birth mother's maternal grand-mother</b>			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:

living    deceased

If deceased, age at death: \_\_\_\_\_ ; and cause of death:

Relative's highest level of education, if known? \_\_\_\_\_

Relative's ethnic background:

Caucasian    African-American    Hispanic    Native American

Asian-American    Other, specify:

multiethnic, specify:

Describe the relative's ancestry, including country of origin and ancestors country of origin.

Describe the relative's religious or spiritual background, if known.

Describe the relative's talents, hobbies, and special interests, if known.

Describe the relative's occupation and employment history, if known.

List or describe this relative's noteworthy accomplishments or use this space to provide additional information regarding the relative.

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Relative	Birth year	Comments about the relationship between birth mother and relative	Relative's physical description
<b>Birth mother's maternal grandfather</b>			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:

living  deceased

If deceased, age at death: \_\_\_\_\_ ; and cause of death:

Relative's highest level of education, if known? \_\_\_\_\_

Relative's ethnic background:

Caucasian  African-American  Hispanic  Native American

Asian-American  Other, specify:

multiethnic, specify:

Describe the relative's ancestry, including country of origin and ancestors country of origin.

Describe the relative's religious or spiritual background, if known.

Describe the relative's talents, hobbies, and special interests, if known.

Describe the relative's occupation and employment history, if known.

List or describe this relative's noteworthy accomplishments or use this space to provide additional information regarding the relative.

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Relative	Birth year	Comments about the relationship between birth mother and relative	Relative's physical description
<b>Birth mother's paternal grand-mother</b>			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:

living  deceased  
 If deceased, age at death: \_\_\_\_\_ ; and cause of death:  
 Relative's highest level of education, if known? \_\_\_\_\_  
 Relative's ethnic background:  
 Caucasian  African-American  Hispanic  Native American  
 Asian-American  Other, specify:  
 multiethnic, specify:  
 Describe the relative's ancestry, including country of origin and ancestors country of origin.  
 Describe the relative's religious or spiritual background, if known.  
 Describe the relative's talents, hobbies, and special interests, if known.  
 Describe the relative's occupation and employment history, if known.

List or describe this relative's noteworthy accomplishments or use this space to provide additional information regarding the relative.

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Relative	Birth year	Comments about the relationship between birth mother and relative	Relative's physical description
<b>Birth mother's paternal grandfather</b>			height: _____ hair color: _____ weight: _____ eye color: _____ other characteristics:

living  deceased

If deceased, age at death: \_\_\_\_\_ ; and cause of death:

Relative's highest level of education, if known? \_\_\_\_\_

Relative's ethnic background:

Caucasian  African-American  Hispanic  Native American

Asian-American  Other, specify:

multiethnic, specify:

Describe the relative's ancestry, including country of origin and ancestors country of origin.

Describe the relative's religious or spiritual background, if known.

Describe the relative's talents, hobbies, and special interests, if known.

Describe the relative's occupation and employment history, if known.

List or describe this relative's noteworthy accomplishments or use this space to provide additional information regarding the relative.

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### 7. Mother's religious or spiritual background

Describe the birth mother's religious or spiritual background.

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**8. Birth mother's education, marital, and work history**

What is the birth mother's education level?

high school graduate    college graduate    graduate degree    other:

Describe the birth mother's marital history.

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What is the birth mother's current occupation? \_\_\_\_\_

Describe the birth mother's employment history.

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**9. Birth mother's criminal history**

Has the birth mother ever been arrested?  Yes  No

If yes, describe the birth mother's criminal history.

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**10. Birth mother's accomplishments and special interests**

Describe the birth mother's talents, hobbies, and special interests.

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Describe the birth mother's noteworthy accomplishments or vocational achievements.

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Detail any additional information about the birth mother, such as her personality type, likes and dislikes, or other noteworthy information.

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## 11. Birth mother's other children

List other children born to the birth mother. Add additional sheets when necessary.

1.	Child's first name	DOB	Gender	Child's physical description
			<input type="checkbox"/> male <input type="checkbox"/> female	height: _____ hair color: _____ weight: _____ eye color: _____
Child is <input type="checkbox"/> full <input type="checkbox"/> half sibling to the child placed for adoption. Child is <input type="checkbox"/> living <input type="checkbox"/> deceased. If deceased, age at death: _____ ; and cause of death:  Describe the child's significant health, psychological, or learning disabilities, if any: 1. 2. 3.  Describe any significant problems with the birth mother's pregnancy with this child.				

2.	Child's first name	DOB	Gender	Child's physical description
			<input type="checkbox"/> male <input type="checkbox"/> female	height: _____ hair color: _____ weight: _____ eye color: _____
Child is <input type="checkbox"/> full <input type="checkbox"/> half sibling to the child placed for adoption. Child is <input type="checkbox"/> living <input type="checkbox"/> deceased. If deceased, age at death: _____ ; and cause of death:  Describe the child's significant health, psychological, or learning disabilities, if any: 1. 2.				

3.

Describe any significant problems with the birth mother's pregnancy with this child.

3.	Child's first name	DOB	Gender	Child's physical description
			<input type="checkbox"/> male <input type="checkbox"/> female	height: _____ hair color: _____ weight: _____ eye color: _____
<p>Child is <input type="checkbox"/> full <input type="checkbox"/> half sibling to the child placed for adoption.</p> <p>Child is <input type="checkbox"/> living <input type="checkbox"/> deceased.</p> <p>If deceased, age at death: _____ ; and cause of death:</p> <p>Describe the child's significant health, psychological, or learning disabilities, if any:</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>Describe any significant problems with the birth mother's pregnancy with this child.</p>				

## 12. Birth mother's behavioral health history

Does the birth mother have any physical challenges or behavioral disabilities such as mental retardation or mental illness?  Yes  No

Has the birth mother been physically or sexually abused?  Yes  No

Has the birth mother been in a relationship that involved domestic violence?  Yes  No

If yes, describe any significant emotional or behavioral history that resulted due to the birth mother's victimization.

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Has the birth mother had any psychiatric or psychological evaluations or treatment, including treatment for drug or alcohol problems?  Yes  No

If yes, explain. Attach additional sheets, if necessary.

1. Symptoms and situation that prompted evaluation or treatment		Birth mother's age at time of symptoms
Diagnosis:	Summary of psychiatric or psychological findings:	Treatment provided:

2. Symptoms and situation that prompted evaluation or treatment		Birth mother's age at time of symptoms
Diagnosis:	Summary of psychiatric or psychological findings:	Treatment provided:

3. Symptoms and situation that prompted evaluation or treatment		Birth mother's age at time of symptoms
Diagnosis:	Summary of psychiatric or psychological findings:	Treatment provided:

### 13. Birth mother's genetic medical history

At what age did the birth mother begin menstruation? \_\_\_\_\_

Indicate if the birth mother or any of the birth mother's blood relatives now have or have ever had any of the medical conditions listed. Blood relatives include birth mother's children, parents, grandparents, aunts, uncles, brothers, sisters, half-brothers, half-sisters, cousins, nieces, or nephews. Do not list relatives related by marriage or adoption.

	Medical condition	Birth mother	Blood relative	Affected person's relationship to birth mother
1.	Blindness or other visual problems such as cataracts or glaucoma If other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	Deafness or hearing difficulties If yes, present from birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Unusual shape or missing ear If yes, <input type="checkbox"/> one ear <input type="checkbox"/> both ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	Speech problems such as delayed speech, stuttering, or articulation disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	Dental problems such as missing or extra teeth or severe malocclusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Cleft lip known as hair lip	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	Cleft palate	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8.	Learning disability or slow learner	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9.	Intellectual disabilities <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe Cause, if known:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10.	Attention Deficit Disorder or Hyperactivity known as ADD or ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11.	Down syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

	Medical condition	Birth mother	Blood relative	Affected person's relationship to birth mother
12.	Chromosome Abnormality If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13.	Mental illness such as manic depression, schizophrenia, or nervous breakdown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14.	Hydrocephalus known as water on the brain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15.	Microcephaly known as small head	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16.	Patches of hair of different color	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17.	Patches of skin of different color such as white or brown spots	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
18.	Birthmarks with an unusual shape, size, or number	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
19.	Skin problems such as severe eczema, acne, or other problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
20.	Bleeding problems or hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
21.	Sickle cell disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
22.	Thalassemia known as Mediterranean or Cooley's anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
23.	High blood pressure known as hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
24.	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
25.	Heart attack or coronary before age 50	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
26.	Born with heart defect such as a hole in the heart	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
27.	Other heart disease If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

	Medical condition	Birth mother	Blood relative	Affected person's relationship to birth mother
28.	Born with spina bifida or open spine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
29.	Born with anencephaly or missing brain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
30.	Born with dislocated hips or other hip problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
31.	Dwarfism or short stature	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
32.	Scoliosis or spinal curvature	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
33.	Unusually formed bones or broken bones not caused by accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
34.	Unusually formed feet such as extra, missing, or webbed toes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
35.	Unusually formed hands such as extra, missing, or webbed fingers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
36.	Club foot	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
37.	Other birth defects If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
38.	Other unusual characteristics If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
39.	Arthritis or joint problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
40.	Muscular dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
41.	Muscle weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
42.	Loss of muscle control	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
43.	Pyloric stenosis or projectile vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	



	Medical condition	Birth mother	Blood relative	Affected person's relationship to birth mother
44.	Breast cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
45.	Colon cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
46.	Ovarian cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
47.	Other cancer If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
48.	Cystic fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
49.	Alzheimer disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
50.	Huntington disease known as chorea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
51.	Neurofibromatosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
52.	Multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
53.	Tay Sachs disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
54.	Cerebral palsy If yes, was there birth trauma? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
55.	Seizures, convulsions, epilepsy If yes, is medication required? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
56.	Childhood diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
57.	Adult diabetes - insulin or non-insulin dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
58.	Thyroid disorder – over or under active	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
59.	Kidney problems If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

	Medical condition	Birth mother	Blood relative	Affected person's relationship to birth mother
60.	Respiratory or breathing problems such as emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
61.	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
62.	Allergies or hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
63.	Allergies to foods If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
64.	Allergies to medications or anesthesia If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
65.	Alcohol dependency or any addiction or predisposition to alcohol addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
66.	Chemical dependency to drugs or any drug addiction or predisposition to drug addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
67.	Weight problems such as obesity or anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
68.	Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
69.	Miscarriages If yes, how many:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
70.	Stillbirths If yes, how many:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
71.	Neonatal deaths before one month of age	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
72.	Infant deaths before one year of age	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
73.	Childhood deaths	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
74.	Human Immunodeficiency Virus known as HIV positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
75.	Acquired Immunodeficiency Syndrome known as AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

	Medical condition	Birth mother	Blood relative	Affected person's relationship to birth mother
76.	Frequent infections or immune deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
77.	Sexually transmitted diseases If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
78.	Gynecological problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
79.	Abnormality of the reproductive organs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Complete the information for any yes answers to questions 1-79 above.

Question number from above	Age when birth mother or blood relative first affected	Comments including: (1) the name of the disorder; (2) period of condition; (3) treatment; and (4) prognosis

Did the birth mother consume any drugs, medication, or alcohol at the time of conception of the child placed for adoption?  Yes  No

Has the birth mother been told that she is a carrier of a genetic or inherited disease?  Yes  No

If yes, specify the disease and whether the birth mother is affected or is a carrier.

Disease:	Birth mother is <input type="checkbox"/> affected or a <input type="checkbox"/> carrier
Disease:	Birth mother is <input type="checkbox"/> affected or a <input type="checkbox"/> carrier
Disease:	Birth mother is <input type="checkbox"/> affected or a <input type="checkbox"/> carrier

List any other potentially inheritable psychological or physical disease, disorder, trait, or tendency of: (1) either birth parent of the child placed for adoption; (2) other children of either birth parent; (3) biological grandparents; or (4) other biological relatives. State the condition and the relationship of the affected person to the child placed for adoption.

Disease or disorder	Affected person's relationship to the child placed for adoption

#### 14. Circumstances leading to adoption

Describe the circumstances leading to this adoption.

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List who in the birth mother's family is aware of the adoption and describe the person's reaction.

Relationship to birth mother	Reaction

The information contained in Section 2. Birth mother's medical and social history was provided by:

- birth mother
- other, specify relationship to birth mother: \_\_\_\_\_
- other, specify relationship to birth mother: \_\_\_\_\_
- other, specify relationship to birth mother: \_\_\_\_\_

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## Section 3: Birth Father's Medical and Social History

### 1. Birth Father's general information

Birth father's date of birth	Place of birth	Birth father's nationality:
The birth father is: <input type="checkbox"/> living <input type="checkbox"/> deceased If deceased, cause of and age at death:		Race or ethnicity <input type="checkbox"/> Caucasian <input type="checkbox"/> African-American <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian-American <input type="checkbox"/> Other: _____ <input type="checkbox"/> Multiethnic, specify:

### 2. Tribal information

Is the birth father a member of a Native American tribe?  Yes  No

Father's tribe	CDIB number	Is father an enrolled tribal member? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Father's tribal enrollment number		

Is the child placed for adoption a member of a Native American tribe?  Yes  No

Child's tribe	CDIB number	Is the child an enrolled tribal member? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Child's tribal enrollment number		

### 3. Birth father's physical characteristics

Birth father's height	Unusual features or birthmarks	
Weight	Eye color	The birth father is: <input type="checkbox"/> right-handed <input type="checkbox"/> left-handed
Natural hair color	Body build	Skin shade <input type="checkbox"/> Light <input type="checkbox"/> medium <input type="checkbox"/> dark

### 4. Birth father's childhood history

Briefly describe the birth father's childhood history.

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## 5. Birth father's siblings

How many full or half brothers does the birth father have? \_\_\_\_\_

How many full or half sisters does the birth father have? \_\_\_\_\_

Describe each sibling. Attach additional sheets, if necessary.

Birth father's sibling	Birth year	Comments about the relationship between birth father and his sibling	Relative's physical description
<input type="checkbox"/> male <input type="checkbox"/> female			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:

living  deceased

If deceased, age at death: \_\_\_\_\_ ; and cause of death:

Describe any significant health, physical, mental, or learning problems, if any, including age at onset.

- 1.
- 2.
- 3.
- 4.

Birth father's sibling	Birth year	Comments about the relationship between birth father and his sibling	Relative's physical description
<input type="checkbox"/> male <input type="checkbox"/> female			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:

living  deceased

If deceased, age at death: \_\_\_\_\_ ; and cause of death:

Describe any significant health, physical, mental, or learning problems, if any, including age at onset.

- 1.
- 2.
- 3.
- 4.



Birth father's sibling	Birth year	Comments about the relationship between birth father and his sibling	Relative's physical description
<input type="checkbox"/> male <input type="checkbox"/> female			height: _____ hair color: _____ weight: _____ eye color: _____ other characteristics:

living    deceased  
If deceased, age at death: \_\_\_\_\_ ; and cause of death: \_\_\_\_\_  
  
Describe any significant health, physical, mental, or learning problems, if any, including age at onset.  
1.  
2.  
3.  
4.

Birth father's sibling	Birth year	Comments about the relationship between birth father and his sibling	Relative's physical description
<input type="checkbox"/> male <input type="checkbox"/> female			height: _____ hair color: _____ weight: _____ eye color: _____ other characteristics:

living    deceased  
If deceased, age at death: \_\_\_\_\_ ; and cause of death: \_\_\_\_\_  
  
Describe any significant health, physical, mental, or learning problems, if any, including age at onset.  
1.  
2.  
3.  
4.

List or describe any of the birth father's sibling's noteworthy accomplishments.

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## 6. Birth father's parents and grandparents

Describe the birth father's relationship with each relative and complete the questions regarding the relative. Attach additional sheets as necessary.

Relative	Birth year	Comments about the relationship between birth father and relative	Relative's physical description
<b>Birth father's mother</b>			height: _____ hair color: _____ weight: _____ eye color: _____ other characteristics:

living  deceased

If deceased, age at death: \_\_\_\_\_ ; and cause of death:

Describe any significant health, physical, mental, or learning problems, if any, including age at onset.

- 1.
- 2.
- 3.
- 4.

Relative's highest level of education?

Describe the relative's religious or spiritual background.

Describe the relative's talents, hobbies, and special interests.

Has the relative been physically or sexually abused?

Yes  No

Has the relative been in a relationship that involved domestic violence?

Yes  No

If yes, describe any significant emotional or behavioral history that resulted due to the relative's victimization.

Describe the relative's occupation and employment history.

Relative	Birth year	Comments about the relationship between birth father and relative	Relative's physical description
<b>Birth father's father</b>			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:

living  deceased

If deceased, age at death: \_\_\_\_\_ ; and cause of death:

Describe any significant health, physical, mental, or learning problems, if any, including age at onset.

- 1.
- 2.
- 3.
- 4.

Relative's highest level of education?

Describe the relative's religious or spiritual background.

Describe the relative's talents, hobbies, and special interests.

Has the relative been physically or sexually abused?

Yes  No

Has the relative been in a relationship that involved domestic violence?

Yes  No

If yes, describe any significant emotional or behavioral history that resulted due to the relative's victimization.

Describe the relative's occupation and employment history.

List or describe the birth father's parents' noteworthy accomplishments or use this space to provide additional information regarding the father's parents.

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Relative	Birth year	Comments about the relationship between birth father and relative	Relative's physical description
<b>Birth father's maternal grand-mother</b>			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:

living     deceased  
 If deceased, age at death: \_\_\_\_\_ ; and cause of death:  
  
 Relative's highest level of education, if known? \_\_\_\_\_  
  
 Relative's ethnic background:  
 Caucasian     African-American     Hispanic     Native American  
 Asian-American     Other, specify:  
 multiethnic, specify:  
  
 Describe the relative's ancestry, including country of origin and ancestors country of origin.  
  
 Describe the relative's religious or spiritual background, if known.  
  
 Describe the relative's talents, hobbies, and special interests, if known.  
  
 Describe the relative's occupation and employment history, if known.

List or describe this relative's noteworthy accomplishments or use this space to provide additional information regarding the relative.

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Relative	Birth year	Comments about the relationship between birth father and relative	Relative's physical description
<b>Birth father's maternal grand-father</b>			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:

living    deceased

If deceased, age at death: \_\_\_\_\_ ; and cause of death:

Relative's highest level of education, if known? \_\_\_\_\_

Relative's ethnic background:

Caucasian    African-American    Hispanic    Native American

Asian-American    Other, specify:

multiethnic, specify:

Describe the relative's ancestry, including country of origin and ancestors country of origin.

Describe the relative's religious or spiritual background, if known.

Describe the relative's talents, hobbies, and special interests, if known.

Describe the relative's occupation and employment history, if known.

List or describe this relative's noteworthy accomplishments or use this space to provide additional information regarding the relative.

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Relative	Birth year	Comments about the relationship between birth father and relative	Relative's physical description
<b>Birth father's paternal grand-mother</b>			height:_____ hair color: _____ weight:_____ eye color: _____ other characteristics:

living  deceased  
 If deceased, age at death: \_\_\_\_\_ ; and cause of death:  
 Relative's highest level of education, if known? \_\_\_\_\_  
 Relative's ethnic background:  
 Caucasian  African-American  Hispanic  Native American  
 Asian-American  Other, specify:  
 multiethnic, specify:  
 Describe the relative's ancestry, including country of origin and ancestors country of origin.  
 Describe the relative's religious or spiritual background, if known.  
 Describe the relative's talents, hobbies, and special interests, if known.  
 Describe the relative's occupation and employment history, if known.

List or describe this relative's noteworthy accomplishments or use this space to provide additional information regarding the relative.

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Relative	Birth year	Comments about the relationship between birth father and relative	Relative's physical description
<b>Birth father's paternal grand-father</b>			height: _____ hair color: _____ weight: _____ eye color: _____ other characteristics:

living    deceased  
 If deceased, age at death: \_\_\_\_\_ ; and cause of death: \_\_\_\_\_  
  
 Relative's highest level of education, if known? \_\_\_\_\_  
  
 Relative's ethnic background:  
 Caucasian    African-American    Hispanic    Native American  
 Asian-American    Other, specify: \_\_\_\_\_  
 multiethnic, specify: \_\_\_\_\_  
  
 Describe the relative's ancestry, including country of origin and ancestors country of origin.  
  
 Describe the relative's religious or spiritual background, if known.  
  
 Describe the relative's talents, hobbies, and special interests, if known.  
  
 Describe the relative's occupation and employment history, if known.

List or describe this relative's noteworthy accomplishments or use this space to provide additional information regarding the relative.

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**7. Father's religious or spiritual background**

Describe the birth father's religious or spiritual background.

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**8. Birth father's education, marital, and work history**

What is the birth father's education level?

high school graduate    college graduate    graduate degree    other:

Describe the birth father's marital history.

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What is the birth father's current occupation? \_\_\_\_\_

Describe the birth father's employment history.

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**9. Birth father's criminal history**

Has the birth father ever been arrested?  Yes  No

If yes, describe the birth father's criminal history.

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**10. Birth father's accomplishments and special interests**

Describe the birth father's talents, hobbies, and special interests.

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Describe the birth father's noteworthy accomplishments or vocational achievements.

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Detail any additional information about the birth father, such as his personality type, likes and dislikes, or other noteworthy information.

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### 11. Birth father's other children

List other children born to the birth father. Add additional sheets when necessary.

1.	Child's first name	DOB	Gender	Child's physical description
			<input type="checkbox"/> male <input type="checkbox"/> female	height: _____ hair color: _____ weight: _____ eye color: _____
Child is <input type="checkbox"/> full <input type="checkbox"/> half sibling to the child placed for adoption. Child is <input type="checkbox"/> living <input type="checkbox"/> deceased. If deceased, age at death: _____ ; and cause of death:  Describe the child's significant health, psychological, or learning disabilities, if any: 1. 2. 3.  Describe any significant problems with the birth mother's pregnancy with this child.				

2.	Child's first name	DOB	Gender	Child's physical description
			<input type="checkbox"/> male <input type="checkbox"/> female	height: _____ hair color: _____ weight: _____ eye color: _____
<p>Child is <input type="checkbox"/> full <input type="checkbox"/> half sibling to the child placed for adoption.</p> <p>Child is <input type="checkbox"/> living <input type="checkbox"/> deceased.</p> <p>If deceased, age at death: _____ ; and cause of death:</p> <p>Describe the child's significant health, psychological, or learning disabilities, if any:</p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> </ol> <p>Describe any significant problems with the birth mother's pregnancy with this child.</p>				

3.	Child's first name	DOB	Gender	Child's physical description
			<input type="checkbox"/> male <input type="checkbox"/> female	height: _____ hair color: _____ weight: _____ eye color: _____
<p>Child is <input type="checkbox"/> full <input type="checkbox"/> half sibling to the child placed for adoption.</p> <p>Child is <input type="checkbox"/> living <input type="checkbox"/> deceased.</p> <p>If deceased, age at death: _____ ; and cause of death:</p> <p>Describe the child's significant health, psychological, or learning disabilities, if any:</p> <ol style="list-style-type: none"> <li>1.</li> <li>2.</li> <li>3.</li> </ol> <p>Describe any significant problems with the birth mother's pregnancy with this child.</p>				

## 12. Birth father's behavioral health history

Does the birth father have any physical challenges or behavioral disabilities such as mental retardation or mental illness?  Yes  No

Has the birth father been physically or sexually abused?  Yes  No

Has the birth father been in a relationship that involved domestic violence?  Yes  No

If yes, describe any significant emotional or behavioral history that resulted due to the birth father's victimization.

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Has the birth father had any psychiatric or psychological evaluations or treatment, including treatment for drug or alcohol problems?  Yes  No

If yes, explain. Attach additional sheets, if necessary.

1. Symptoms and situation that prompted evaluation or treatment		Birth father's age at time of symptoms
Diagnosis:	Summary of psychiatric or psychological findings:	Treatment provided:

2. Symptoms and situation that prompted evaluation or treatment		Birth father's age at time of symptoms
Diagnosis:	Summary of psychiatric or psychological findings:	Treatment provided:

3. Symptoms and situation that prompted evaluation or treatment		Birth father's age at time of symptoms
Diagnosis:	Summary of psychiatric or psychological findings:	Treatment provided:

### 13. Birth father's genetic medical history

Indicate if the birth father or any of the birth father's blood relatives now have or have ever had any of the medical conditions listed. Blood relatives include birth father's children, parents, grandparents, aunts, uncles, brothers, sisters, half-brothers, half-sisters, cousins, nieces, or nephews. Do not list relatives related by marriage or adoption.

	Medical condition	Birth father	Blood relative	Affected person's relationship to birth father
1.	Blindness or other visual problems such as cataracts or glaucoma If other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	Deafness or hearing difficulties If yes, present from birth? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	Unusual shape or missing ear If yes, <input type="checkbox"/> one ear <input type="checkbox"/> both ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	Speech problems such as delayed speech, stuttering, or articulation disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	Dental problems such as missing or extra teeth or severe malocclusion	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	Cleft lip known as hair lip	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	Cleft palate	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

	Medical condition	Birth father	Blood relative	Affected person's relationship to birth father
8.	Learning disability or slow learner	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9.	Intellectual disabilities <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe Cause, if known:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10.	Attention Deficit Disorder or Hyperactivity known as ADD or ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
11.	Down syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
12.	Chromosome Abnormality If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
13.	Mental illness such as manic depression, schizophrenia, or nervous breakdown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
14.	Hydrocephalus known as water on the brain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
15.	Microcephaly known as small head	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
16.	Patches of hair of different color	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
17.	Patches of skin of different color such as white or brown spots	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
18.	Birthmarks with an unusual shape, size, or number	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
19.	Skin problems such as severe eczema, acne, or other problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
20.	Bleeding problems or hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
21.	Sickle cell disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
22.	Thalassemia known as Mediterranean or Cooley's anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

	Medical condition	Birth father	Blood relative	Affected person's relationship to birth father
23.	High blood pressure known as hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
24.	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
25.	Heart attack or coronary before age 50	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
26.	Born with heart defect such as a hole in the heart	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
27.	Other heart disease If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
28.	Born with spina bifida or open spine	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
29.	Born with anencephaly or missing brain	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
30.	Born with dislocated hips or other hip problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
31.	Dwarfism or short stature	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
32.	Scoliosis or spinal curvature	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
33.	Unusually formed bones or broken bones not caused by accident	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
34.	Unusually formed feet such as extra, missing, or webbed toes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
35.	Unusually formed hands such as extra, missing, or webbed fingers	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
36.	Club foot	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
37.	Other birth defects If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
38.	Other unusual characteristics If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

	Medical condition	Birth father	Blood relative	Affected person's relationship to birth father
39.	Arthritis or joint problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
40.	Muscular dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
41.	Muscle weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
42.	Loss of muscle control	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
43.	Pyloric stenosis or projectile vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
44.	Breast cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
45.	Colon cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
46.	Ovarian cancer		<input type="checkbox"/> Yes <input type="checkbox"/> No	
47.	Other cancer If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
48.	Cystic fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
49.	Alzheimer disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
50.	Huntington disease known as chorea	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
51.	Neurofibromatosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
52.	Multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
53.	Tay Sachs disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
54.	Cerebral palsy If yes, was there birth trauma? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

	Medical condition	Birth father	Blood relative	Affected person's relationship to birth father
55.	Seizures, convulsions, epilepsy If yes, is medication required? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
56.	Childhood diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
57.	Adult diabetes - insulin or non-insulin dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
58.	Thyroid disorder – over or under active	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
59.	Kidney problems If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
60.	Respiratory or breathing problems such as emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
61.	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
62.	Allergies or hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
63.	Allergies to foods If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
64.	Allergies to medications or anesthesia If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
65.	Alcohol dependency or any addiction or predisposition to alcohol addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
66.	Chemical dependency to drugs or any drug addiction or predisposition to drug addiction	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
67.	Weight problems such as obesity or anorexia	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
68.	Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
69.	Miscarriages If yes, how many:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
70.	Stillbirths If yes, how many:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	



	Medical condition	Birth father	Blood relative	Affected person's relationship to birth father
71.	Neonatal deaths before one month of age	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
72.	Infant deaths before one year of age	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
73.	Childhood deaths	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
74.	Human Immunodeficiency Virus known as HIV positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
75.	Acquired Immunodeficiency Syndrome known as AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
76.	Frequent infections or immune deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
77.	Sexually transmitted diseases If yes, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
78.	Gynecological problems		<input type="checkbox"/> Yes <input type="checkbox"/> No	
79.	Abnormality of the reproductive organs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Complete the information for any yes answers to questions 1-79 above.

Question number from above	Age when birth father or blood relative first affected	Comments including: (1) the name of the disorder; (2) period of condition; (3) treatment; and (4) prognosis

Did the birth father consume any drugs, medication, or alcohol at the time of conception of the child placed for adoption?  Yes  No

Has the birth father been told that he is a carrier of a genetic or inherited disease?  Yes  No

If yes, specify the disease and whether the birth father is affected or is a carrier.

Disease:	Birth father is <input type="checkbox"/> affected or a <input type="checkbox"/> carrier
Disease:	Birth father is <input type="checkbox"/> affected or a <input type="checkbox"/> carrier
Disease:	Birth father is <input type="checkbox"/> affected or a <input type="checkbox"/> carrier

List any other potentially inheritable psychological or physical disease, disorder, trait, or tendency of: (1) either birth parent of the child placed for adoption; (2) other children of either birth parent; (3) biological grandparents; or (4) other biological relatives. State the condition and the relationship of the affected person to the child placed for adoption.

Disease or disorder	Affected person's relationship to the child placed for adoption

#### 14. Circumstances leading to adoption

Describe the circumstances leading to this adoption.

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List who in the birth father's family is aware of the adoption and describe the person's reaction.

Relationship to birth father	Reaction

The information contained in Section 3. Birth father's medical and social history was provided by:

- birth father
- other, specify relationship to birth father: \_\_\_\_\_
- other, specify relationship to birth father: \_\_\_\_\_
- other, specify relationship to birth father: \_\_\_\_\_