

Center for Health Statistics

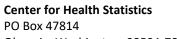
PO Box 47814 Olympia, Washington 98504-7814 360.236.4300

Birth Parent Medical History

Indicate if information is unknown or not available.

For each of the medical conditions described below, please check the appropriate column indicating whether you or any blood relative, i.e. your mother/parent, father/parent, sister, brother, grandparent, aunt, uncle or any other children, have the condition listed. Complete the "Comments" section, as needed using a separate sheet of paper if additional space is required.

MEDICAL CONDITION	NO	YES (SELF)	YES (RELATIVE)	NOT KNOWN	COMMENTS (indicate which relative in relation to adoptee)
			letal/musc		(indicate which relative in relation to adoptee
1. Club foot					
2. Cleft lip or cleft palate					
3. Arthritis (Osteo or Rheumatoid)					
4. Scoliosis or other malformations					
5. Spina bifida					
	Ne	uromu	scular/aut	 oimmun	e
6. Muscular dystrophy					Part of body involved?
					Age at onset?
7. Multiple sclerosis					
8. Cerebral palsy					
9. Other paralysis or crippling disorder					
10. Seizures, convulsions or epilepsy					Age at onset? What treatment? Frequency?
11. Huntington's disease					
12. Lupus					
		Vis	sual/audito	ry	
 Blindness, glaucoma or other visual problems 					
14. Glaucoma					





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MEDICAL CONDITION	NO	YES (SELF)	YES (RELATIVE)	NOT KNOWN	COMMENTS (indicate which relative in relation to adoptee)
15. Other visual problems					
16. Deafness or other ear problems					
Internal organs/conditions					
17. Hepatitis					Specify type
18. Cirrhosis or other liver disease					
19. Kidney disease					Age at onset? Treatment?
20. Inflammatory bowel					
21. Other intestinal conditions					
22. Diabetes					Age at onset? Treatment?
23. Thyroid disorder (hyper/hypo)					
24. Other hormonal disorder					
25. Cancer					Location? Onset?
		Hea	art/circulate	ory	10.000.
26. Congenital heart defect					
27. Heart attack					
28. Stroke					
29. Atherosclerosis					
30. Congestive heart failure					
31. High blood pressure					
32. Hemophilia					
33. Other cardiovascular problems					



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MEDICAL CONDITION	NO	YES (SELF)	YES (RELATIVE)	NOT KNOWN	COMMENTS (indicate which relative in relation to adoptee)
		F	Respiratory	У	
34. Emphysema					
35. Asthma					
36. Allergies					
37. Cystic fibrosis					
38. Tuberculosis					
		Oth	er condition	ons	
39. Schizophrenia					
40 Depression or hipolar					Any diagnosis or cause?
40. Depression or bipolar					Hospitalized?
41. Other mental illness					
42. Eating disorder					
					Age at onset?
43. Learning disability					Cause?
,					Special Education?
44. Alcoholism or drug addiction					
					Age at onset?
45. Any other conditions you or your relatives might have.					Treatment?
					Hospitalization?
IN	FOR	MATIO	ON THIS	PREGN	ANCY
Month prenatal care began for this pregnand	cy:				
Complications, if any:					



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INFORMATION ON THIS PREGNANCY
Exposure during pregnancy (e.g. alcohol, prescription or recreational drugs, Diethylstilbestrol (DES)?
Specify:
Amount and frequency:
Did you use alcohol during pregnancy? Yes ☐ No ☐
Amount and frequency:
Did you use tobacco during pregnancy? Yes ☐ No ☐
Amount and frequency:
CHILD'S BIRTH HISTORY
Any Comments:
OTHER INFORMATION ON BIRTH PARENTS (OPTIONAL) Give information only at the time of the child's birth. Do not include any identifying information.
Name of child on original (pre adoption) birth certificate:
Child's date of birth: Sex: ☐ Male ☐ Female ☐ X ☐ Unknown
City or county of birth:
Today's Date: