Washington State Department of Health

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, father, 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.

Person completing this form is: ☐ Birth Mother ☐ Birth Father

MEDICAL CONDITION	**NO**	**YES** (SELF)	**YES** (RELATIVE)	**NOT KNOWN**	**COMMENTS** (indicate which relative in relation to adoptee)
Skeletal/muscular					
1. Club foot					
2. Cleft lip or cleft palate					
3. Arthritis (Osteo or Rheumatoid)					
4. Scoliosis or other malformations					
5. Spina bifida					
Neuromuscular/autoimmune					
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					
Visual/auditory					
13. 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?
Heart/circulatory					
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)
Respiratory					
34. Emphysema					
35. Asthma					
36. Allergies					
37. Cystic fibrosis					
38. Tuberculosis					
Other conditions					
39. Schizophrenia					
40. Depression or bipolar					Any diagnosis or cause? Hospitalized?
41. Other mental illness					
42. Eating disorder					
43. Learning disability					Age at onset? Cause? Special Education?
44. Alcoholism or drug addiction					
45. Any other conditions you or your relatives might have.					Age at onset? Treatment? Hospitalization?

INFORMATION ON THIS PREGNANCY
Month prenatal care began for this pregnancy:
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

City or county of birth:

Today's Date: