Genetic and Medical History of Child and Biological Family

Date Completed: Child's Name:

Form Completed By:

If information is unknown ("unk") or not available ("N/A") please indicate.

A. Birth Information

Birth Date: Time: Gestational Age:

Birthplace Hospital: City/State):

Measurements at Birth:

Weight: Length: Head: Chest:

Caesarian: ☐ Yes ☐ No Spontaneous Birth: ☐ Yes ☐ No

APGAR Scores:

Presentation at Birth: ☐ Breech ☐ Vertex ☐ OA

Duration of Labor: ☐ Assisted: ☐ Forceps ☐ Vacuum

Resuscitation Required: ☐ Yes ☐ No If yes, how long?

Type of Birth: ☐ Single ☐ Multiple If multiple, how many?

Birth Record Additional Comments:

Discharge Weight: Discharge Date:

Breast Fed: ☐ Yes ☐ No If yes, how long?

Formula:

List of Medications Given	
Mother	**Baby**

Date of Circumcision (if applicable): Child's Blood Type/RH Factor:

Serology on Infant Completed: ☐ Yes ☐ No If yes, Date: Results: PKU Date: PKU Number:

Coombs Test Completed: ☐ Yes ☐ No Results:

Birth Defects/Other Physical Problems:

Check any of the following that have been present:

☐ Convulsions ☐ Cyanosis ☐ Congenital Condition
☐ Jaundice ☐ Tremors ☐ Pallor

Sexually Transmitted Disease diagnosed in child at time of birth, if any (specify):

THIS FORM IS AVAILABLE IN ALTERNATIVE FORMAT UPON REQUEST

Childs Name

If American Indian or Alaskan Native, specify name of tribe and degree of Indian blood (if known)

Race:
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Multi-Racial (Specify):
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Unable to Determine

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Nationality (specify):
- ☐ Unable to Determine

B. CHILD'S PRENATAL EXPOSURE TO ALCOHOL OR OTHER CONTROLLED SUBSTANCES

Type	Select One	Which Trimester	Frequency	Amount	How Taken	Comments (include source of information)
1. Alcohol (beer, wine, etc.)	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
2. Amphetamines (uppers)	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
3. Barbiturates (downers)	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
4. Tobacco	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
5. Cocaine (crack)	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
6. Heroin	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
7. LSD	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
8. PCP	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
9. Marijuana	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
10. Inhalants	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
11. Methadone	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
12. Methamphetamine	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
13. Other (specify):	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
	☐ Yes ☐ No ☐ Unknown	Select One			Select One	
	☐ Yes ☐ No ☐ Unknown	Select One			Select One	

Confirmed Diagnosis of: Fetal Alcohol Effect: ☐ Yes ☐ No

Date of Diagnosis: Name of Evaluator:

Fetal Alcohol Syndrome: ☐ Yes ☐ No

Childs Name

Date of Diagnosis: Name of Evaluator:

C. CHILD'S HEALTH HISTORY

Indicate conditions child has had and approximate date:

- ☐ Rubella (3 day)
- ☐ Rubella (2 week)
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Meningitis
- ☐ Other Specify:
- ☐ Rosella
- ☐ Asthma
- ☐ Hay Fever
- ☐ Encephalitis
- ☐ Whooping Cough
- ☐ Ear Infection
- ☐ Heart Murmur
- ☐ Urinary/Bladder Infection

Has the child experienced any of the following?	Select One	Comments (Name of person reporting information and date of occurrence if known)
1. Head Injuries	☐ Yes ☐ No ☐ Unknown	
2. Fractures	☐ Yes ☐ No ☐ Unknown	
3. Other Injuries /Traumas	☐ Yes ☐ No ☐ Unknown	
4. Physical Abuse	☐ Yes ☐ No ☐ Unknown	
5. Sexual Abuse	☐ Yes ☐ No ☐ Unknown	
6. Neglect	☐ Yes ☐ No ☐ Unknown	
7. Multiple Caretakers	☐ Yes ☐ No ☐ Unknown	
8. Failure to Thrive	☐ Yes ☐ No ☐ Unknown	
9. Hospitalizations	☐ Yes ☐ No ☐ Unknown	
10. Drug Abuse	☐ Yes ☐ No ☐ Unknown	

D. CHILD'S IMMUNIZATION HISTORY

Immunizations and Date(s) Given:

- ☐ Immunizations Complete
- ☐ Incomplete, but up-to-date
- ☐ Date scheduled:
- ☐ Pneumococcal Conjugate:
- ☐ Other:

- ☐ DTP (Diphtheria/Tetanus/Pertussis)
- ☐ Varicella (Chicken Pox)
- ☐ Polio
- ☐ MMR (Measles/Mumps/Rubella)
- ☐ HIB (Influenza)
- ☐ HEP B (Hepatitis B)
- ☐ T B (Tuberculosis)

E. CHILD'S CURRENT INFORMATION

Developmental History: (expressed in months)
Toilet Trained: Feeding: Other:

Physical Description of Child:
Current Age: Hair Color: ☐ Small-Boned:
Eye Color: Usual Weight: ☐ Large Boned:
Body Type: Skin Color: ☐ Medium-Boned:
Height:

Describe any distinguishable physical features: (e.g., birthmarks, scars, etc.)

F. BIRTH MOTHER'S HISTORY DURING THIS PREGNANCY

Age when birth mother became pregnant: When did Prenatal Care begin?
Pregnancies: Number of Live Births: Miscarriages:
Conditions during this Pregnancy:
Infection: Virus: German Measles:
Mother's blood type: Mother's RH Factor:
Sexually Transmitted: ☐ Herpes ☐ Chlamydia ☐ Syphilis
☐ Gonorrhea ☐ Genital Warts ☐ Other:

If any of the above items were checked, please specify type of condition(s), date(s) and type of treatment:

Is the biological father a genetic relative of the mother? ☐ Yes ☐ No
If yes, degree of relationship:
Father's Blood Type: Father's RH Factor:
Exposure to toxic environmental conditions or substances: (specify)

Other: (Complications or accidents during pregnancy, indications of anemia, etc.) Specify and explain:

HIV Test? ☐ Yes ☐ No If "Yes" give Date:

G. MEDICATIONS TAKEN BY BIRTH MOTHER DURING AND WITHIN 6 MONTHS BEFORE OR AFTER THIS PREGNANCY

Non-Prescription Drugs: (list names) including Aspirin, Nose Drops, etc	Taken When?	Why Taken?	Approx. Time Period	How Often?
	Select One			
	Select One			
	Select One			
	Select One			
	Select One			

Prescription Drugs: (list names)	Taken When?	Why Taken?	Approx. Time Period	How Often
	Select One			
	Select One			
	Select One			
	Select One			
	Select One			

H. MEDICAL CONDITIONS OF CHILD AND CHILD'S BIOLOGICAL FAMILY

Condition	**Child**	**Mother's Family** (list relationship to child) e.g., parent, grandparent, aunt, uncle, sibling	**Father's Family** (list relationship to child) e.g., parent, grandparent, aunt, uncle, sibling	**Comments** (also list name of person reporting information; if condition resulted in death, note here)
1. Respiratory				
Allergies				
Asthma				
Bronchitis				
Emphysema				
Tuberculosis				
Cystic Fibrosis				

Other comments regarding medication:

Gastrointestinal	**Child**	**Mother's Family**	**Father's Family**	**Comments**
Ulcers				
Inflammatory Bowel				
Other				

Cardiovascular	**Child**	**Mother's Family**	**Father's Family**	**Comments**
High Blood Pressure				
Heart Attack				
Stroke				
Congestive Heart Failure				
Atherosclerosis				
Heart Rhythm Abnormality				
Congenital Heart Defect				

4. Immune/ Hematological	Child	**Mother's Family** (list relationship to child) e.g., parent, grandparent, aunt, uncle, sibling	**Father's Family** (list relationship to child) e.g., parent, grandparent, aunt, uncle, sibling	**Comments** (also list name of person reporting information; if condition resulted in death, note here)
Mononucleosis				
Hemophilia				
Leukemia				
Lymphomas				
Hodgkin's Disease				
Other Cancer (type?)				

5. Renal	Child	Mother's Family	Father's Family	Comments
Kidney Failure/Dialysis/ Transplant				
Other Kidney Problems				

6. Liver Disease	Child	Mother's Family	Father's Family	Comments
Hepatitis (specify type)				
Cirrhosis				
Other Liver Disease				

7. Central Nervous System	Child	Mother's Family	Father's Family	Comments
Epilepsy				
Hydrocephalus				
Multiple Sclerosis				
Huntington's Chorea				
Seizures/ Convulsions				

8. Endocrine	Child	Mother's Family	Father's Family	Comments
Diabetes (Adult or Juvenile) – list treatment				
Thyroid (hyper/hypo)				
Adrenal				

9. Muscular/ Skeletal	Child	**Mother's Family** (list relationship to child) e.g., parent, grandparent, aunt, uncle, sibling	**Father's Family** (list relationship to child) e.g., parent, grandparent, aunt, uncle, sibling	**Comments** (also list name of person reporting information; if condition resulted in death, note here)
Club Foot				
Scoliosis(Curvature of the Spine)				
Arthritis (Osteo or Rheumatoid)				
Cleft lip or Palate				
Lupus				

10.Neuromuscular	Child	Mother's Family	Father's Family	Comments
Cerebral Palsy				
Muscular Dystrophy				
Spina Bifida				

11.Visual/Auditory	Child	Mother's Family	Father's Family	Comments
Blindness				
Glaucoma				
Cataracts or other eye problems				
Deafness or other hearing problems				

I. OTHER MEDICAL CONDITIONS OF CHILD AND CHILD'S BIOLOGICAL FAMILY				
12. Mental Illness (list type, e.g., Depression, Bipolar, Schizophrenia				
13. Alcohol or Drug Abuse				
14. Eating Disorders				
15. Mental Retardation				
16. Give age at death & cause of death of child's grand-parent, aunt, uncle, and siblings:				
17. Other				

J BIRTH PARENT'S FAMILY HISTORY

Were you or any family member of your immediate family adopted? ☐ Yes ☐ No

If yes, please tell which family member:

Childs Name

	BIRTH MOTHER	BIRTH FATHER
Date of Birth (or approximate age of D.O.B. is unknown)		
If deceased, age at and cause of death.		
Height & Weight		
Eye Color/Skin Tone		
Hair Color & Texture		
Build (e.g., petite, large boned)		
Personality		
Religion		

Race BIRTH MOTHER	Race BIRTH FATHER
☐ Asian	☐ Asian
☐ American Indian or Alaskan Native	☐ American Indian or Alaskan Native
If American Indian or Alaskan Native, specify name of tribe and degree of Indian blood (if known):	If American Indian or Alaskan Native, specify name of tribe and degree of Indian blood (if known):
☐ Black or African American	☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander	☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Unable to Determine	☐ White ☐ Unable to Determine
Multi-Racial (specify):	Multi-Racial (specify):
Ethnicity BIRTH MOTHER	**Ethnicity BIRTH FATHER**
☐ Hispanic or Latino	☐ Hispanic or Latino
☐ Not Hispanic or Latino	☐ Not Hispanic or Latino
☐ Unable to Determine	☐ Unable to Determine
Nationality:	Nationality:

Other Information: