Ohio Department of Job and Family Services

SOCIAL AND MEDICAL HISTORY

(Completion of the entire form is mandated by ORC 3107.09)

CHILD'S INFORMATION

Name of Child	Date of Birth *(mm/dd/yyyy)*	Date Form Completed *(mm/dd/yyyy)*

You are being asked to provide family history information at a time that we know is difficult for you, however, this information may be important at some point in providing medical care for your child. There are many medical conditions that can run in families. We are trying to obtain a completed medical history because your child may need this information in the future. Please answer the questions as best as you can. If you have any questions about how to answer anything, please ask your worker for help. Each birth parent should complete a social and medical history form.

HISTORY OF BIOLOGICAL PARENTS

Sometimes children are born to parents who are related by blood. These children may have a higher chance of having health problems. For this reason we need to know if there is any blood relationship between the birth parents. If the child's parents are related by blood, please check the two (2) boxes that describe the relationship. (For example, the child's mother married her uncle or half brother)

☐ Father	☐ Mother	☐ Daughter
☐ Brother	☐ Sister	☐ Son
☐ Cousin	☐ Uncle	☐ Aunt
☐ Half Sister	☐ Niece	☐ Other, please specify _____

MARITAL HISTORY OF BIOLOGICAL PARENTS

The biological parents were

☐ Never Married ☐ Married Now ☐ Divorced ☐ Widowed

DELIVERY AND BIRTH INFORMATION OF THE CHILD

How long was the birth mother in labor?	Was the Delivery ☐ Vaginal ☐ Cesarean

If Cesarean, why?

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

If "Yes," please explain

The baby was born ☐ Breech ☐ Head First ☐ Don't Know

Was there a heart murmur at birth? ☐ Yes ☐ No ☐ Don't Know

If "Yes," please explain

Were any problems noted AT birth? ☐ Yes ☐ No ☐ Don't Know

If "Yes," please explain

Were any problems noted AFTER birth? ☐ Yes ☐ No ☐ Don't Know

If "Yes," please explain

BIRTH AND MEDICAL HISTORY

Sex	Date of Birth *(mm/dd/yyyy)*
☐ Male ☐ Female	

Was the child born
☐ At Term ☐ Premature ☐ Post Mature

If Premature, how many weeks	If Post Mature, how many weeks

Child's Weight *(at birth)*	Child's Birth Length *(in inches)*

Child's Blood Type	Child's RH
☐ A ☐ B ☐ AB ☐ O	☐ Positive ☐ Negative ☐ Don't Know

APGAR Score
☐ One Minute ☐ Five Minutes ☐ Don't Know

Were any of the following Newborn Screening Tests Positive?

PKU *(phenylketonuria)*	☐ Yes	☐ No	☐ Don't Know
Galactosemia	☐ Yes	☐ No	☐ Don't Know
Hypothyroidism	☐ Yes	☐ No	☐ Don't Know
Sickle Cell Disease	☐ Yes	☐ No	☐ Don't Know
Other *(specify)*	☐ Yes	☐ No	☐ Don't Know

In what month of your pregnancy did you first see a health care worker?

☐ One Month	☐ Two Months	☐ Three Months
☐ Four Months	☐ Five Months	☐ Six Months
☐ Seven Months	☐ Eight Months	☐ Nine Months

Did you, or do you have, or were you exposed to any of the following during your pregnancy?

	Yes	No	Don't Know	What Month in Pregnancy?	If Yes, Specify Diagnosis, Site, or Kind
Fever *(101 degrees or over)*	☐	☐	☐		
Infection	☐	☐	☐		
Rashes	☐	☐	☐		
X-Rays/Radiation	☐	☐	☐		
Chemicals	☐	☐	☐		
Toxic/Hazardous Waste	☐	☐	☐		
Sexually Transmitted Disease	☐	☐	☐		
HIV/AIDS	☐	☐	☐		
Diabetes	☐	☐	☐		
Measles *(red/rubella)*	☐	☐	☐		
Mumps/Chicken Pox	☐	☐	☐		
High Blood Pressure	☐	☐	☐		
Toxemia	☐	☐	☐		
Domestic Abuse	☐	☐	☐		

BIRTH AND MEDICAL HISTORY

Did you take any of the following during your pregnancy? If, Yes, how much a week did you take?

	Yes	No	Don't Know	What Month in Pregnancy	How Much per Week
Alcohol (include beer/wine)	☐	☐	☐		
Caffeine	☐	☐	☐		
Cigarettes	☐	☐	☐		
☐ Cocaine / ☐ Crack *(check)*	☐	☐	☐		
☐ Heroin / ☐ Methadone *(check)*	☐	☐	☐		
☐ LSD / ☐ Acid *(check)*	☐	☐	☐		
Marijuana	☐	☐	☐		
Amphetamines (Uppers)	☐	☐	☐		
Barbiturates *(Downers)*	☐	☐	☐		
Others *(Specify)*	☐	☐	☐		
Other *(Specify)*	☐	☐	☐		

For the following medications, please list the names of the medications, if known.

	Yes	No	Don't Know	What Month In Pregnancy	How Much Per Week
Prescription Drug	☐	☐	☐		
Over the Counter Medication	☐	☐	☐		
Seizure Medication	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		
Other	☐	☐	☐		

SOCIAL/MEDICAL HISTORY OF THE BIRTH MOTHER

Mother's Age

Year of Birth

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

General Physical Description *(i.e., hair color, eye color, height)*

Highest grade in school she completed *(check one)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

College/University

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduated

Where you ever in special education classes? *(classes designed to help in learning)* ☐ Yes ☐ No

List awards, honors, and/or scholarships in high school

SOCIAL/MEDICAL HISTORY OF THE BIRTH MOTHER, cont.

Actively participated in school sponsored events, such as

Plans for further education and/or vocational goal, include

Other educational comments

Are you currently employed? ☐ Yes ☐ No

Current Employment *(type of job)*

Previous Employer *(type of job*)

Religious Affiliation

Do you have a preference about the religious affiliation for you child? ☐ Yes ☐ No

If Yes, specify

Are you adopted? ☐ Yes ☐ No ☐ Don't Know

Have you had any major illnesses? ☐ Yes ☐ No

If Yes, explain

Do you have or have you had any mental illness? ☐ Yes ☐ No

If Yes explain and tell about the treatment

Have you ever been told you have a genetic/inherited disease? ☐ Yes ☐ No

If Yes, please explain?

Have you ever been told you are a carrier of a genetic/inherited disease? ☐ Yes ☐ No

If Yes, what disease?

Describe any other children you have *(i.e., the children's brother and sisters)*: List in order of birth and the children who may have died. If a child died, please indicate age at death and the cause of death.

Relationship	Date of Birth	Health/Medical Problems

Have you ever had any miscarriages? ☐ Yes ☐ No

If Yes, how many?

How many living brothers do you have?

Did you have any brothers who died? ☐ Yes ☐ No

Age at Death	Cause of Death	Medical problem, if cause of death

How many living sister do you have?

SOCIAL/MEDICAL HISTORY OF THE BIRTH MOTHER, cont.

Did you have any sisters who died? ☐ Yes ☐ No

Age at Death	Cause of Death	Medical problem, if cause of death

Do any of your brothers or sisters have a different father or mother?

If Yes, please indicate which brother or sister and which parent was different from yours

Birth Mother's Parents

Mother's year of birth

Has she had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

If she is dead: cause of death and age

Highest grade in school she completed *(check one)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Did she receive special education? ☐ Yes ☐ No ☐ Don't Know

Father's year of birth

Has he had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

If he is dead: cause of death and age

Highest grade in school he completed *(check one)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Did he receive special education? ☐ Yes ☐ No ☐ Don't Know

Birth Mother's Grandparents

Birth Mother's Maternal Grandmother

Has she had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American

☐ Hispanic ☐ Pacific Islander ☐ Asian

☐ Other, please list

SOCIAL/MEDICAL HISTORY OF THE BIRTH MOTHER, cont.

Birth Mother's Maternal Grandfather

Has he had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

Birth Mother's Paternal Grandmother

Has she had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

Birth Mother's Paternal Grandfather

Has she had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH MOTHER

Genetic Medical History: Indicate by checking "YES" or "NO" if you or any blood relative (i.e. Your parents, grandparents, aunts, uncles, brothers, sisters, nieces, and nephews) ever had or Now have any of the medical conditions listed. Include only relatives who are your blood relatives (omitting relatives only by marriage or adoption, but including half-brothers and half-sisters). Indicate all relatives in terms of their relationship to you.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
1. Blindness or other Visual Problems *(i.e. Cataracts)*	☐	☐	☐	☐	
2. Hearing Impaired Difficulties/Unusual shape or ear missing	☐	☐	☐	☐	
3. Speech Problems	☐	☐	☐	☐	
4. Dental Problems *(i.e., missing tooth or extra tooth)*	☐	☐	☐	☐	
5. Cleft Lip *(harelip)*	☐	☐	☐	☐	
6. Cleft Palate	☐	☐	☐	☐	
7. Learning Disability or Slow Learner	☐	☐	☐	☐	
8. Mental Retardation	☐	☐	☐	☐	
9. Attention Deficit Disorder and/or Hyperactivity	☐	☐	☐	☐	
10. Down Syndrome	☐	☐	☐	☐	
11. Other Chromosome Abnormality *(specify)*	☐	☐	☐	☐	
12. Mental Illness *(e.g. manic depression,,schizophrenia, nervous breakdown)*	☐	☐	☐	☐	
13. Hydrocephalus *(water on the brain)*	☐	☐	☐	☐	
14. Microcephaly *(small head)*	☐	☐	☐	☐	
15. Patches of Hair of Different Color	☐	☐	☐	☐	
16. Patches of Skin of Different Color	☐	☐	☐	☐	
17. Birthmarks *(i.e., unusual shape, size or number)*	☐	☐	☐	☐	
18. Skin Problems *(i.e., severe eczema, acne)*	☐	☐	☐	☐	
19. Bleeding Problems or Hemophilia	☐	☐	☐	☐	
20. Sickle Cell Disease	☐	☐	☐	☐	
21. Thalassemia *(inherited anemia)*	☐	☐	☐	☐	
22. High Blood Pressure *(hypertension)*	☐	☐	☐	☐	
23. Stroke	☐	☐	☐	☐	
24. Heart Disease before age 50 *(Coronary)*	☐	☐	☐	☐	
25. Born with Heart Defect *(i.e., whole in the heart)*	☐	☐	☐	☐	
26. Born with Open Spine *(Spina Befida)*	☐	☐	☐	☐	

If "Yes" to any of the above, please answer the following:

Number *(from above)*	Age, When First Affected	Relationship	Comment

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH MOTHER, cont.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
27. Born with Missing Brain *(anencephaly)*	☐	☐	☐	☐	
28. Born with Hip Problems *(dislocated hips)*	☐	☐	☐	☐	
29. Dwarfism or Short Statue	☐	☐	☐	☐	
30. Spinal Curvature *(Scoliosis)*	☐	☐	☐	☐	
31. Unusually Formed Bones or Many Broken Bones	☐	☐	☐	☐	
32. Unusually Formed Hands *(i.e., extra, missing, webbed fingers)*	☐	☐	☐	☐	
33. Unusually Formed Feet *(example; extra, missing, webbed toes)*	☐	☐	☐	☐	
34. Club Foot	☐	☐	☐	☐	
35. Other Birth Defects *(Not listed, please specify)*	☐	☐	☐	☐	
36. Arthritis	☐	☐	☐	☐	
37. Muscular Dystrophy	☐	☐	☐	☐	
38. Muscle Weakness	☐	☐	☐	☐	
39. Loss of Muscle Control	☐	☐	☐	☐	
40. Pyloric SteNosis *(projectile vomiting)*	☐	☐	☐	☐	
41. Breast Cancer	☐	☐	☐	☐	
42. Colon Cancer	☐	☐	☐	☐	
43. Ovarian Cancer	☐	☐	☐	☐	
44. Other Cancers *(type, site)*	☐	☐	☐	☐	
45. Cystic Fibrosis	☐	☐	☐	☐	
46. Alzheimer Disease	☐	☐	☐	☐	
47. Huntington Disease	☐	☐	☐	☐	
48. Neurofibromatosis *(benign tumor)*	☐	☐	☐	☐	
49. Multiple Sclerosis	☐	☐	☐	☐	
50. Tay Sachs Disease	☐	☐	☐	☐	
51. Cerebral Palsy	☐	☐	☐	☐	
52. Seizures, Convulsions, Epilepsy	☐	☐	☐	☐	
53. Childhood Diabetes	☐	☐	☐	☐	
54. Adult Diabetes *(insulin active or over active)*	☐	☐	☐	☐	

If "Yes" to any of the above, please answer the following:

Number *(from above)*	Age, When First Affected	Relationship	Comment

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH MOTHER, cont.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
55. Thyroid Disorder *(under active or over active)*	☐	☐	☐	☐	
56. Kidney Problems	☐	☐	☐	☐	
57. Respiratory or Breathing Problems	☐	☐	☐	☐	
58. Asthma	☐	☐	☐	☐	
59. Allergies/Hay Fever *(pollen)*	☐	☐	☐	☐	
60. Allergies Food *(specify)*	☐	☐	☐	☐	
61. Allergies Medicine *(specify)*	☐	☐	☐	☐	
62. Chemical Dependency *(alcohol)*	☐	☐	☐	☐	
63. Chemical Dependency ***(other drug-specify)***	☐	☐	☐	☐	
64. Weight Problems *(obesity or anorexia)*	☐	☐	☐	☐	
65. Infertility	☐	☐	☐	☐	
66. Miscarriages If "Yes" how many	☐	☐	☐	☐	
67. Stillbirths If "Yes" how many	☐	☐	☐	☐	
68. Neonatal Deaths *(died before one month old)*	☐	☐	☐	☐	
69. Infants Death *(died before one year of age)*	☐	☐	☐	☐	
70. Childhood Deaths	☐	☐	☐	☐	
71. HIV *Positive (Human Immunodeficiency Virus)*	☐	☐	☐	☐	
72. AIDS *(Acquired Immunodeficiency Syndrome)*	☐	☐	☐	☐	
73. Frequent Infections *(immunodeficiency)*	☐	☐	☐	☐	

If "Yes" to any of the above, please answer the following:

Number *(from above)*	Age, When First Affected	Relationship	Comment

SOCIAL/MEDICAL HISTORY OF THE BIRTH FATHER

Father's Age	Year of Birth

His ANCESTRY: Country of origin of his ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

General Physical Description *(i.e., hair color, eye color, height)*

Highest grade in school he completed *(check one)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

College/University

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduated

Was he ever in special education classes? *(classes designed to help in learning)* ☐ Yes ☐ No

List awards, honors, and/or scholarships in high school

Actively participated in school sponsored events, such as

Plans for further education and/or vocational goal, include

Other educational comments

Is he currently employed? ☐ Yes ☐ No

Current Employment *(type of job)*

Previous Employer *(type of job*)

Religious Affiliation

Does he have a preference about the religious affiliation for the child? ☐ Yes ☐ No

If Yes, specify

Was he adopted? ☐ Yes ☐ No ☐ Don't Know

Has he had any major illnesses? ☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Does he have or has he had any mental illness? ☐ Yes ☐ No ☐ Don't Know

If Yes explain and tell about the treatment

Has he ever been told he had a genetic/inherited disease? ☐ Yes ☐ No

If Yes, please explain?

Has he ever been told he was a carrier of a genetic/inherited disease? ☐ Yes ☐ No

If Yes, what disease?

SOCIAL/MEDICAL HISTORY OF THE BIRTH FATHER, cont.

Describe any other children he has *(i.e., the children's brother and sisters)*: List in order of birth and the children who may have died. If a child died, please indicate age at death and the cause of death.

Relationship	Date of Birth	Health/Medical Problems

How many living brothers does he have?

Does he have any brothers who died? ☐ Yes ☐ No

Age at Death	Cause of Death	Medical problem, if cause of death

How many living sister does he have?

Did he have any sisters who died? ☐ Yes ☐ No

Age at Death	Cause of Death	Medical problem, if cause of death

Do any of his brothers or sisters have a different father or mother?

If Yes, please indicate which brother or sister and which parent was different

Birth Father's Parents

Mother's year of birth

Has she had any serious health problems including physical, mental, or learning?
☐ Yes ☐ No ☐ Don't Know

If Yes, explain

If she is dead: cause of death and age

Highest grade in school she completed *(check one)*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Did she receive special education? ☐ Yes ☐ No ☐ Don't Know

Father's year of birth

Has he had any serious health problems including physical, mental, or learning?
☐ Yes ☐ No ☐ Don't Know

If Yes, explain

If he is dead: cause of death and age

Highest grade in school he completed *(check one)*
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12

Did he receive special education?
☐ Yes ☐ No ☐ Don't Know

Birth Father's Grandparents

Father's Maternal Grandmother

Has she had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

Father's Maternal Grandfather

Has he had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

His ANCESTRY: Country of origin of his ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

Father's Paternal Grandmother

Has she had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

Her ANCESTRY: Country of origin of her ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

Father's Paternal Grandfather

Has he had any serious health problems including physical, mental, or learning?

☐ Yes ☐ No ☐ Don't Know

If Yes, explain

His ANCESTRY: Country of origin of his ancestors *(for example, Italy, Scotland, etc.)*

Race/Ethnic Background

☐ African American ☐ White ☐ Native American
☐ Hispanic ☐ Pacific Islander ☐ Asian
☐ Other, please list

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH FATHER

Genetic Medical History: Indicate by checking "Yes" or "No" if you or any blood relative (i.e. Your parents, grandparents, aunts, uncles, brothers, sisters, nieces, and nephews) ever had or Now have any of the medical conditions listed. Include only relatives who are your blood relatives (omitting relatives only by marriage or adoption, but including half-brothers and half-sisters). Indicate all relatives in terms of their relationship to you.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
1. Blindness or other Visual Problems *(i.e. Cataracts)*	☐	☐	☐	☐	
2. Hearing Impaired Difficulties Unusual shape or ear missing	☐	☐	☐	☐	
3. Speech Problems	☐	☐	☐	☐	
4. Dental Problems *(i.e., missing tooth or extra tooth)*	☐	☐	☐	☐	
5. Cleft Lip *(harelip)*	☐	☐	☐	☐	
6. Cleft Palate	☐	☐	☐	☐	
7. Learning Disability or Slow Learner	☐	☐	☐	☐	
8. Mental Retardation	☐	☐	☐	☐	
9. Attention Deficit Disorder and/or Hyperactivity	☐	☐	☐	☐	
10. Down Syndrome	☐	☐	☐	☐	
11. Other Chromosome Abnormality *(specify)*	☐	☐	☐	☐	
12. Mental Illness *(e.g. manic depression, schizophrenia, nervous breakdown)*	☐	☐	☐	☐	
13. Hydrocephalus *(water on the brain)*	☐	☐	☐	☐	
14. Microcephaly *(small head)*	☐	☐	☐	☐	
15. Patches of Hair of Different Color	☐	☐	☐	☐	
16. Patches of Skin of Different Color	☐	☐	☐	☐	
17. Birthmarks *(i.e., unusual shape, size or number)*	☐	☐	☐	☐	
18. Skin Problems *(i.e., severe eczema, acne)*	☐	☐	☐	☐	
19. Bleeding Problems or Hemophilia	☐	☐	☐	☐	
20. Sickle Cell Disease	☐	☐	☐	☐	
21. Thalassemia *(inherited anemia)*	☐	☐	☐	☐	
22. High Blood Pressure *(hypertension)*	☐	☐	☐	☐	
23. Stroke	☐	☐	☐	☐	
24. Heart Disease before age 50 *(Coronary)*	☐	☐	☐	☐	

Number *(from above)*	Age, When First Affected	Relationship	Comment

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH FATHER, cont.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
25. Born with Heart Defect *(i.e., whole in the heart)*	☐	☐	☐	☐	
26. Born with Open Spine *(Spina Befida)*	☐	☐	☐	☐	
27. Born with Missing Brain *(anencephaly)*	☐	☐	☐	☐	
28. Born with Hip Problems *(dislocated hips)*	☐	☐	☐	☐	
29. Dwarfism or Short Statue	☐	☐	☐	☐	
30. Spinal Curvature *(Scoliosis)*	☐	☐	☐	☐	
31. Unusually Formed Bones or Many Broken Bones	☐	☐	☐	☐	
32. Unusually Formed Hands *(i.e., extra, missing, webbed fingers)*	☐	☐	☐	☐	
33. Unusually Formed Feet *(example; extra, missing, webbed toes)*	☐	☐	☐	☐	
34. Club Foot	☐	☐	☐	☐	
35. Other Birth Defects *(Not listed, please specify)*	☐	☐	☐	☐	
36. Arthritis	☐	☐	☐	☐	
37. Muscular Dystrophy	☐	☐	☐	☐	
38. Muscle Weakness	☐	☐	☐	☐	
39. Loss if Muscle Control	☐	☐	☐	☐	
40. Pyloric Stenosis *(projectile vomiting)*	☐	☐	☐	☐	
41. Breast Cancer	☐	☐	☐	☐	
42. Colon Cancer	☐	☐	☐	☐	
43. Ovarian Cancer	☐	☐	☐	☐	
44. Other Cancers *(type, site)*	☐	☐	☐	☐	
45. Cystic Fibrosis	☐	☐	☐	☐	
46. Alzheimer Disease	☐	☐	☐	☐	
47. Huntington Disease	☐	☐	☐	☐	
48. Neurofibromatosis *(benign tumor)*	☐	☐	☐	☐	
49. Multiple Sclerosis	☐	☐	☐	☐	
50. Tay Sachs Disease	☐	☐	☐	☐	
51. Cerebral Palsy	☐	☐	☐	☐	
52. Seizures, Convulsions, Epilepsy	☐	☐	☐	☐	
53. Childhood Diabetes	☐	☐	☐	☐	
54. Adult Diabetes *(insulin active or over active)*	☐	☐	☐	☐	

If "Yes" to any of the above, please answer the following:

Number *(from above)*	Age, When First Affected	Relationship	Comment

GENETIC/MEDICAL FAMILY HISTORY OF BIRTH FATHER, cont.

Special Medical Conditions	Yourself Yes	Yourself No	Blood Relative Yes	Blood Relative No	Relationship to Person
55. Thyroid Disorder *(under active or over active)*	☐	☐	☐	☐	
56. Kidney Problems	☐	☐	☐	☐	
57. Respiratory or Breathing Problems	☐	☐	☐	☐	
58. Asthma	☐	☐	☐	☐	
59. Allergies/Hay Fever *(pollen)*	☐	☐	☐	☐	
60. Allergies Food *(specify)*	☐	☐	☐	☐	
61. Allergies Medicine *(specify)*	☐	☐	☐	☐	
62. Chemical Dependency *(alcohol)*	☐	☐	☐	☐	
63. Chemical Dependency *(other drug-specify)*	☐	☐	☐	☐	
64. Weight Problems *(obesity or anorexia)*	☐	☐	☐	☐	
65. Infertility	☐	☐	☐	☐	
66. Miscarriages If "Yes" how many	☐	☐	☐	☐	
67. Stillbirths If "Yes" how many	☐	☐	☐	☐	
68. Neonatal Deaths *(died before one month old)*	☐	☐	☐	☐	
69. Infants Death *(died before one year of age)*	☐	☐	☐	☐	
70. Childhood Deaths	☐	☐	☐	☐	
71. HIV Positive *(Human Immunodeficiency Virus)*	☐	☐	☐	☐	
72. AIDS *(Acquired Immunodeficiency Syndrome)*	☐	☐	☐	☐	
73. Frequent Infections *(immunodeficiency)*	☐	☐	☐	☐	

If "Yes" to any of the above, please answer the following:

Number *(from above)*	Age, When First Affected	Relationship	Comment

Prepared By

Assessor	Certificate Number