State of Connecticut
Department of Children and Families

MEDICAL INFORMATION ON GENETIC PARENT(S)

☐ Mother *(Use separate form for each parent)* ☐ Father

Indicate by checking **"Yes"** or **"No"** if you or any **genetic relatives** (i.e. your mother, father, sisters, brothers, grandparents, aunts, uncles, or any other children you have had) ever had, or now have, the medical items listed. Also complete the **"Comment"** section.

Medical Condition	No	Not Known	Yes (Self)	Yes - Relative (Specify which relative)	Comments (Provide details including, but not limited to, cause, age at onset, treatment and any hospitalizations)
1. Club Foot					
2. Harelip (Cleft Lip) or cleft palate					
3. Congenital heart defect					
4. Any other malformations					
5. Muscular dystrophy					
6. Multiple sclerosis					
7. Cerebral palsy					
8. Other paralysis or crippling disorder					
9. Seizures, convulsions or epilepsy					
10. Blindness, glaucoma or other visual problems					
11. Deafness or other ear problems					
12. Speech problem					
13. Learning disability					
14. Developmental disability: mental or physical					
15. Diabetes					
16. Thyroid disorder					
17. Other hormone disorder					
18. Eczema or other skin conditions					

Medical Condition	No	Not Known	Yes (Self)	Yes - Relative (Specify which relative)	Comments (Provide details including, but not limited to, cause, age at onset, treatment and any hospitalizations)
19. Asthma					
20. Hay fever or other allergy					
21. Hemophilia					
22. Sickle cell anemia					
23. Other blood disease (including anemia)					
24. Schizophrenia					
25. Manic depressive					
26. Other mental or emotional illness					
27. Hypertension (high blood pressure)					
28. Stroke					
29. Heart attack (Coronary)					
30. Other Cardiovascular Problems					
31. Cancer					
32. Tumors					
33. Cystic fibrosis					
34. Huntington's disease					
35. Tuberculosis					
36. Kidney disease					

Medical Condition	No	Not Known	Yes (Self)	Yes - Relative (Specify which relative)	Comments (Provide details including, but not limited to, cause, age at onset, treatment and any hospitalizations)
37. Alcoholism or heavy drinking					
38. Drug usage					
39. Hospitalization, operation, or injury					
40. Any other condition you or others in your family might have					

Initials: Adoptive Parent 1: _____ Adoptive Parent 2: _____

For Genetic Mother Only

Menstrual and Pregnancy History			
Age at onset of menses	**Usual Length of Period**	**Regular?** ☐ **Yes** ☐ **No**	**Number of Days Between**

Please list all your pregnancies in order. (Use one line for each child or for each miscarriage, abortion, or still birth.)

Children (Write baby boy, baby girl, miscarriage, abortion, or still-birth)	**How Many Months Did You Carry This Pregnancy?**	**Year in Which Pregnancy Ended**	**If Miscarriage or Abortion, Was it Natural or Induced?**

This Pregnancy

Is the baby's father aware of this pregnancy? ☐ **Yes** ☐ **No** ☐ **Not Sure**	**Is the baby's father a genetic relative of yours? If yes, how is he related?** ☐ **Yes** ☐ **No**
Month prenatal care began for this pregnancy	**Complications**
Exposure during pregnancy ☐ **X-Ray** ☐ **Electrocardiogram** ☐ **Radiation**	

Drugs Taken During Pregnancy

Prescription Drugs	**Prescription Drugs**		
Non-Prescription Drugs	**Non-Prescription Drugs *(including aspirin and/or nose drops)* When and frequency during pregnancy**		
Alcohol	☐ **Yes** ☐ **No**	**Amount**	**How Often**
Amphetamines *(Uppers)*	**When During Pregnancy?**	**Kind**	**Amount**
Barbiturates *(Downers)*	**Kind**	**Amount**	
Cocaine	**When**	**Amount**	
Heroin	**When**	**Amount**	
LSD	**When**	**Amount**	
Marijuana	**When**	**Amount**	
Cigarettes	**When**	**Amount**	

Birth History

Child's Name	Date of Birth	Time of Birth (A.M. or P.M.)	Sex	Weight Lbs. Oz.

Term						Head Circumference	Chest Circumference
☐ Premature	Weeks	☐ Postmature	Weeks	☐ Full	Weeks		

Abnormalities		
Mother's Blood Type	RH Factor	Baby's Blood Type

Duration of Labor	Anesthesia Used	

Type of Delivery	Apgar Score at 1 and 5 Minutes	Condition of Child at Birth
	/	

Child's Medical History

First Tooth At *(months)*	Sat Alone *(months)*	Walked At *(months)*	Convulsive Disorder *(month and year noted)*

Toilet Trained *(months)*	Diagnosed Medical Conditions *(i.e., allergies, bronchitis, etc.)*

Attach Medical Passport and Do Not Complete if Immunizations, Diseases and Hospitals Information are Contained on Passport

Immunizations	Date	Booster Date	Booster Date	Booster Date
DPT	/ /	/ /	/ /	/ /
Small Pox	/ /	/ /	/ /	/ /
Polio	/ /	/ /	/ /	/ /
Other:	/ /	/ /	/ /	/ /

Diseases (Dates)

Measles	/ /	Whooping Cough	/ /
Mumps	/ /	Other (Specify):	/ /
Chicken Pox	/ /		/ /

Hospitalization *(Reason, Date(s) and Place)*

Complete the Following:

Test	Date	Performed by
Psychological Evaluation	/ /	
Psychiatric Evaluation	/ /	
Intellectual Assessment	/ /	
Developmental Evaluation (includes Speech, Language and Hearing)	/ /	
Physical Examination	/ /	
Neurological Evaluation	/ /	
Other:	/ /	

I hereby acknowledge receipt of a copy of this form.	**Signed *(adoptive parent 1)***	**Date**	**Signed *(adoptive parent 2)***	**Date**

Signed (Agency Representative)	**Date**	**Agency**