

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Name of Agency _____

Division of Social Services
Adoption Health History, Part I

Adoptee's First Name _____

Source of information, if not completed by parent

I. BIRTH MOTHER'S MENSTRUAL & PREGNANCY HISTORY INVOLVING THIS CHILD

Age at onset of menses	Usual length of period	Regular <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of days between periods
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II. THIS PREGNANCY

Mother's age at onset of pregnancy?	Full term? <input type="checkbox"/> Yes <input type="checkbox"/> No	When did pre-natal care begin? How many visits?
Complications during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If complications, explain	Single birth _____ Multiple births 1. ____ 2. ____ 3. ____ 4. ____ Number of prior pregnancies

III. DELIVERY HISTORY OF THIS CHILD

Duration of Labor	Type of delivery <input type="checkbox"/> Natural <input type="checkbox"/> Cesarean	Forceps <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's blood type _____ Mother's blood type _____ Mother's RH factor _____
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Were you given anesthesia? Yes No

IV. CONDITIONS DURING THIS PREGNANCY

German Measles <input type="checkbox"/> Yes <input type="checkbox"/> No	Infections <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemic <input type="checkbox"/> Yes <input type="checkbox"/> No
Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Accidents <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No
Virus <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" specify _____	Pre-Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No
Toxemia <input type="checkbox"/> Yes <input type="checkbox"/> No		

COMMENTS:

INSTRUCTIONS: One copy of this form is to be given to the adoptive parents prior to placement of a minor child for adoption; one copy is to be filed with the Petition for Adoption to be forwarded by the Clerk of Superior Court to the Division of Social Services, State Department of Health and Human Services; and one copy is to be retained in the agency's file. In agency adoptions, the certification page shall not be provided to the adoptive parent(s) if it contains the name of a birth parent or birth parent's relative.

Health History of Biological Parents and Other Relatives, Part 11

Indicate Birth Mother _____
 Birth Father _____

Instructions: Use separate sheet for each parent. Fill in above space to indicate which parent the information concerns.

Adoptee's First Name _____

Respiratory System	No	Yes (self)	Yes Relative (specify)	Comments
Allergies				
Hay fever				
Asthma				
Sinusitis				
Tuberculosis				
Emphysema				
Cystic Fibrosis				
Other (specify)				
Skin				
Acne				
Warts				
Psoriasis				
Eczema				
Baldness				
Cancer				
Birth Defects				
Harelip/cleft palate				
Clubfoot				
Heart defect				
Cerebral Palsy				
Downs Syndrome				
Chemical Dependency/Abuse				Amount/Frequency
Alcohol				
Tobacco				
Marijuana				
Barbiturates				
Amphetamines				
Hallucinogenics				
Cocaine				
Heroin				
Prescription drugs				
Tranquilizers				
Others				
Hereditary Diseases				
Hemophilia				
Thyroid Disorder				
Galactosemia				
Huntington's Disease				
Obesity				
Sickle Cell Anemia				
Other (specify)				

Adoptee's First Name _____

Bones/Muscle Disorders	No	Yes (self)	Yes Relative (specify)	Specify degree and age at onset:
Arthritis/Rheumatism				
Osteoporosis				
Knee & Hip Disorder				
Scoliosis				
Spina Bifida				
Muscular Dystrophy				
Lupus				
Heart Circulatory				
Aneurysm				
Varicose Veins				
Heart Murmur				
High blood pressure				
Stroke				
Heart attack				
Blockages				
Angina				
Phlebitis				
Other (specify):				
Neurological Disorders				What part of body? Both sides? How severe?
Muscular Dystrophy				
Multiple Sclerosis				
Cerebral Palsy				
Parkinson's Disease				
Alzheimer's Disease				
Epilepsy/Seizures				
Migraines				
Schizophrenia				
Tay Sachs Disease				
Tourette Syndrome				
Depression				
Autism				
Attention Deficit Disorder				
Sexually Transmitted Diseases				
Gonorrhea				
Syphilis				
Herpes				
HIV Carrier				
AIDS				
Other (specify)				
Urinary				
Kidney Disease				
Bladder Infections				
Gout				
Kidney Stones				
Sugar				
Liver Disorders:				
Pancreatic Disorders:				

Adoptee's First Name _____

Rheumatic Fever	No	Yes (self)	Yes Relative (specify)	Did heart murmur result?
Sense Organ Disorders				Age at Onset
Blindness				
Far/near sighted				
Astigmatism				
Ear infections				
Wears glasses/contacts				
Speech problems				
Color/night blindness				
Glaucoma-, Cataracts				
Deafness/hearing loss				
Other (specify)				
Major Injury/Surgery:				Age?
Physical or Sexual Abuse:				Age? Perpetrator?
Breast History				
Cancer				
Mastectomy				
Lumpectomy				
Fibrocystic				
Other (specify)				
SIDS				
Mental Retardation:				Any diagnosis or cause? Hospitalized?
Hyperactive/Learning Disabilities:				Type of education? Type of medication?
Lung Disease:				Specify type:
Diabetes:				Specify type; age at diagnosis, medications:
Dental Problems:				Specify type:
Cancer				What Kind? Age at Onset? Part of Body?

CERTIFICATION

This document should be certified by the person who prepared it. (In agency adoptions, this certification page shall not be provided to the adoptive parent(s) if it contains the name of a birth parent or birth parent's relative.)

I hereby certify that I prepared this Adoption Health History Form, Parts I and 11.

Signature of (Parent) (Relative) (Agency)

Date: _____

STATE OF NORTH CAROLINA

_____ COUNTY

Sworn to and subscribed before me this _____ day of _____, _____

(S E A L)

Notary Public

My Commission Expires: _____