OFFICE OF COMMUNITY SERVICES
STATEMENT OF FAMILY HISTORY
MEDICAL/GENETIC HISTORY OF BIOLOGICAL FAMILIES
Signed and Given at time of surrender in TPR

Date:_____ Child's TIPS #:_____

INFORMANT (NO NAMES: IDENTIFY BY RELATIONSHIP TO CHILD) _____

BIOLOGICAL PARENTS	DATE OF BIRTH	AGE OF MOTHER AT BIRTH	HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	COMPLEXION	RACE	NATIONALITY	RELIGION	EDUCATION
MOTHER											
FATHER											

ILLNESSES/CONDITIONS	BIRTH MOTHER YES	BIRTH FATHER YES	GRANDMOTHER YES	GRANDFATHER YES	OTHER RELATIVE YES	SPECIFY RELATIVE
AIDS/HIV Infection						
Allergies/Hay Fever - Specify*						
Arthritis						
Asthma						
Blindness/Sight Loss/Eye Disease						
Blood Disease - Specify*						
Cancer						
Cerebral Palsy						
Clubfoot/Orthopedic Problems						
Congenital Heart Defect						
Congenital Malformations						
Deafness/Hearing Loss/Ear Problems						
Death prior to age 50 of any family						
Diabetes						
Drug Addiction/Drug Related Problem*						
Epilepsy						
Excessive Use of Alcohol						
Glandular Disturbance - Specify*						
Harelip/Cleft Palate						
Heart Problems						
Hemophilia						
Hepatitis B - Specify*						
High Blood Pressure - Specify*						
Kidney Ailments						
Learning Disability						
Mental Illness - Specify*						
Mental Retardation - Specify*						
Multiple Sclerosis						
Muscular Dystrophy						
Neurological/Muscular Disorder - Specify						
Psychiatric Illness						
Seizures/Convulsions/Epilepsy						
Sickle Cell Anemia						
Sickle Cell Trait						
Speech Problems						
Stroke						
Thyroid Problems						
Tuberculosis						
Venereal Disease - Specify*						
Other - Specify						
Other - Specify						

*PLEASE USE THIS SPACE TO EXPLAIN ALL "YES" ANSWERS AND SPECIFY TYPES OF DISORDER IF APPROPRIATE. (IF YES FOR GRANDPARENTS, PLEASE IDENTIFY AS PATERNAL, MATERNAL OR BOTH.) ATTACH EXTRA PAGE WITH INFORMATION IF NEEDED.

(Specify) Please state whether the minor child has had the following shots or tests:

YES NO
( ) ( ) 2 mos. DPT + OPV
( ) ( ) 4 mos. DPT + OPV
( ) ( ) 6 mos. DPT
( ) ( ) 9 mos. MGB
( ) ( ) 12 mos. TB
( ) ( ) 15 mos. MMR
( ) ( ) AIDS/HIV Test

YES NO
( ) ( ) 18 mos. DPT + OPV Booster Comments: _____
( ) ( ) 24 mos. TB _____
( ) ( ) 36 mos. TB _____
( ) ( ) 48 mos. TB _____
( ) ( ) 5 yrs. DPT + OPV Booster _____
( ) ( ) 5 yrs. TB

Please state whether the minor child has been diagnosed
YES NO
( ) ( ) Mentally Retarded (Specify) _____
( ) ( ) Learning Disabled (Specify) _____

Currently under physician, psychologist, psychiatric care? Yes _____ No_____
Diagnosis: _____
Medications: _____

Please state whether the minor child has had the following illnesses:

YES NO
( ) ( ) Pertussis
( ) ( ) Rubella
( ) ( ) Mumps
( ) ( ) Chicken Pox
( ) ( ) Scarlet Fever
( ) ( ) Diphtheria
( ) ( ) Glandular Disturbance
_____
( ) ( ) Pneumonia
( ) ( ) Chronic Ear Infections
( ) ( ) Sickle Cell Anemia
( ) ( ) Other _____ (Specify)
( ) ( ) Allergies _____
( ) ( ) Drug Exposure/Withdrawal _____ Cocaine/Crack (Specify)

YES NO
( ) ( ) Appendicitis
( ) ( ) Rheumatic Fever
( ) ( ) Tonsillitis
( ) ( ) Convulsions
( ) ( ) Asthma
( ) ( ) Drug Exposure - Other
( ) ( ) Venereal Disease _____ (Specify)
( ) ( ) Accidental Injuries _____ (Specify)

Operations_____
_____
_____

FAMILY HISTORY

AGES OF BIOLOGICAL GRANDPARENTS: (at time of surrender)	IF DECEASED, AT WHAT AGE?	
PATERNAL GRANDMOTHER _____	PATERNAL GRANDMOTHER_____	CAUSE OF DEATH_____
PATERNAL GRANDFATHER _____	PATERNAL GRANDFATHER:_____	CAUSE OF DEATH _____
MATERNAL GRANDMOTHER _____	MATERNAL GRANDMOTHER _____	CAUSE OF DEATH_____
MATERNAL GRANDFATHER _____	MATERNAL GRANDFATHER _____	CAUSE OF DEATH_____

IF EITHER BIRTH PARENT IS DECEASED, AT WHAT AGE?	STATE CAUSE OF DEATH_____
BIRTH MOTHER _____	_____
BIRTH FATHER _____	_____

ANY FAMILY HISTORY OF MULTIPLE BIRTHS?

BIRTH MOTHER:_____ BIRTH FATHER_____

THIS PREGNANCY

Month Prenatal Care Began For This Pregnancy: _____ Blood Type _____

Mother Father

Complications?_____ Birth Weight: _____ lbs. _____oz. _____Unknown

Apgar Score: _____

DRUGS TAKEN DURING THIS PREGNANCY:

Medications:

Prescription:_____

Non-Prescription (including aspirin and/or nose drops):_____

_____

When During Pregnancy?_____

Maternal Infections During Pregnancy: _____ X-Ray _____ Trauma _____ Other (Bleeding, High BP, Premature Labor, etc.)_____

Other Drugs:

A. Alcohol _____ Amount: _____ How Often:_____

B. Amphetamines (Uppers) When During Pregnancy?_____

Kind: _____ Amount:_____

C. Barbiturates (Downers) Kind:_____ When:_____ Amount:_____

D. Cocaine/Crack When:_____ _____ _____ Amount:_____

E. Heroin When:_____ _____ _____

Amount:_____

_____

F. LSD When:_____ _____ _____ Amount:_____

G. Marijuana When:_____ _____ _____ Amount:_____

H. Cigarettes When:_____ _____ _____ Amount:_____

I. Caffeine When:_____ _____ _____ Amount:_____

1st Trimester 2nd Trimester 3rd Trimester

Head Circumference_____ Chest Circumference_____

DELIVERY:	YES	NO	UNK
NORMAL	____	____	____
CAESAREAN	____	____	____
MEDICATED	____	____	____
BREECH	____	____	____
OTHER	____	____	____
COMPLICATIONS	____	____	____
RESUSCITATION	____	____	____
PREMATURE	____	____	____

If so, number of weeks:_____

Multiple birth (Explain)_____

Gestation Period _____ weeks

Number of Siblings:

_____ _____

FULL HALF

PLEASE USE THIS SPACE FOR ANY NECESSARY EXPLANATIONS:_____

_____

_____

_____

_____

_____

_____

_____

The child's mother (____ agrees ____ disagrees), father (____ agrees ____ disagrees) to the future release of nonidentifying or identifying information in the event of a medical necessity for which information is needed in order to treat the child. This information must be used according to agency policy.

Del. *

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The agency or person to whom a surrender is made shall have the duty to make a good faith effort to obtain the nonidentifying information, to deliver it to prospective adoptive parents upon placement, and to disclose the information upon request of the adopted child upon his attaining the age of eighteen in the event that such information was never otherwise made available to him.

Should the agency or person to whom a surrender is made fail to obtain all required nonidentifying information, the agency or person shall document by affidavit the good faith efforts made to obtain such information and that such efforts were unproductive.

Acknowledgment of Receipt of Statement of Family History.

_____ _____ _____

ADOPTIVE MOTHER ADOPTIVE FATHER DATE