DHS
Oregon Department
of Human Services

Birth Parent Updated Medical History

Name of Child on original birth record: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female Hospital: _____

County: _____ City: _____

Mother's Name (as shown on birth certificate): _____

Adoption agency involved with adoption (if known): _____

Today's Date: _____ Person completing this form is: ☐ Birth Mother ☐ Birth Father

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

MEDICAL CONDITIONS OF CHILD'S BIOLOGICAL FAMILY

Mother's Family & Father's Family Please list relationship to child e.g. parent, grandparent, aunt, uncle, sibling, etc.

Condition	Mother's Family*	Father's Family*	Comments (also list name of person reporting information; if condition resulted in death, note here)
1. Respiratory			
Allergies			
Asthma			
Bronchitis			
Emphysema			
Tuberculosis			
Cystic Fibrosis			
2. Gastrointestinal			
Ulcers			
Inflammatory Bowel			
Cleft lip or palate			
Other			

THIS FORM IS AVAILABLE IN ALTERNATE FORMAT UPON REQUEST

Child's Name: _____

***Mother's Family & Father's Family Please list relationship to child e.g. parent, grandparent, aunt, uncle, sibling, etc.**

Condition	Mother's Family*	Father's Family*	Comments (also list name of person reporting information; if condition resulted in death, note here)
3. Cardiovascular			
High Blood Pressure			
Heart Attack			
Stroke			
Congestive Heart Failure			
Atherosclerosis			
Heart Rhythm Abnormality			
Congenital Heart Defect			
4. Condition Immune/Hematologic			
Mononucleosis			
Hemophilia			
Leukemia			
Lymphomas			
Hodgkin's Disease			
Other Cancer (type?)			
5. Condition Renal			
Kidney Failure/ Dialysis/ Transplant			
Other Kidney Problems			

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Child's Name: _____

***Mother's Family & Father's Family** Please list relationship to child e.g. parent, grandparent, aunt, uncle, sibling, etc.

Condition	Mother's Family*	Father's Family*	Comment (name of person reporting information; if condition resulted in death, note here)
6. Liver Disease			
Hepatitis (specify type)			
Cirrhosis			
Other Liver Disease			
7. Condition Central Nervous System			
Epilepsy			
Hydrocephalus			
Multiple Sclerosis			
Huntington's Chorea			
Seizures/ Convulsions			
8. Endocrine			
Diabetes (Adult or Juvenile) - list treatment			
Thyroid (hyper/hypo)			
Adrenal			
9. Muscular/Skeletal			
Club Foot			
Scoliosis (Curvature of the Spine)			
Arthritis (Osteo or Rheumatoid)			
Lupus			

***Mother's Family & Father's Family** Please list relationship to child e.g. parent, grandparent, aunt,

Child's Name: _____

uncle, sibling, etc.

Condition	Mother's Family*	Father's Family*	Comments (also list name of person reporting information; if condition resulted in death, note here)
10. Neuromuscular			
Cerebral Palsy			
Muscular Dystrophy			
Spina Bifida			
11. Visual/Auditory			
Blindness			
Glaucoma			
Cataracts or Other Eye Problems (specify)			
Deafness or Other Hearing Problems (specify)			
Other Conditions			
12. Mental Illness List type:(e.g., Depression, Biopolar, Schizophrena)			
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:			

Please return this completed form to:

Human Services Building
Adoptions, 2nd Floor South
500 Summer Street NE, E 71
Salem, Oregon 97301-1068

Or the private agency involved in the adoption.

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