

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			

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			

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*	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,

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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:

**ODHS Adoptions, Search and Registry
500 Summer Street NE, E-71
Salem, Oregon 97301-106**

Or the private agency involved in the adoption.

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