BIRTH MOTHER'S
SOCIAL AND MEDICAL HISTORY

Birth Mother's Personal Information:

MOTHER'S FULL NAME:	**BIRTH DATE:**
PLACE OF BIRTH:	**Social Security Number:**

HEIGHT:	**WEIGHT:**	**EYE COLOR:**
SKIN COLOR/COMPLEXION:	**HAIR COLOR/TYPE/LENGTH:**	**ETHNICITY/CULTURAL HERITAGE:**
BUILD:	**RIGHT or LEFT HANDED:**	**BLOOD TYPE:**

Age of Onset of Menstruation:	**Menstrual Problems:**
Dental History (braces, root canals, cavities, crowns):	
Does she wear glasses? ☐ YES ☐ NO	**If Yes:** ☐ Astigmatic ☐ Far Sighted ☐ Near Sighted ☐ Amblyopia (Lazy eye) ☐ Strabismus (Cross-eyed)

DESCRIPTION OF PERSONALITY:

SIGNIFICANT CHILDHOOD EVENTS:

EMPLOYMENT HISTORY:

HOBBIES, SPECIAL SKILL, OR TALENTS:

PLANS FOR HER FUTURE:

PSYCHOLOGICAL COUNSELING HISTORY:

TRIBAL INFORMATION, IF APPLICABLE:

Additional Information/Summary:

Birth Mother's History -- RELIGION & EDUCATION:

Religious Affiliation:	**Degree of Religious Interest:**
Number of Years Attended School:	**Scholastic Performance:**
Favorite School Subjects:	

Additional Information/Summary:

Birth Mother's Marital/Significant Relationship Information:

Date of Marriage (or Significant Relationship)	To	Date Relationship Ended

BIRTH MOTHER -- BIRTH FAMILY HISTORY:

Mother's Name:	DOB/Age:	Whereabouts:	Historic Relationship/Connection with this Child:
			Historic Relationship/Connection with this Child:

Father's Name:	**DOB/Age:**	**Whereabouts:**	
Sisters Name:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
Sisters Name:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
Sisters Name:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
Brothers Name:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
Brothers Name:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
Brothers Name:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**

Maternal Grandmother:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
Maternal Grandfather:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
Maternal Aunt:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
Maternal Aunt:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
Maternal Uncle:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
Maternal Uncle:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**

Paternal Grandmother:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
Paternal Grandfather:	DOB/Age:	Whereabouts:	Historic Relationship/Connection with this Child:
Paternal Aunt:	DOB/Age:	Whereabouts:	Historic Relationship/Connection with this Child:

Paternal Aunt:	DOB/Age:	Whereabouts:	Historic Relationship/Connection with this Child:
Paternal Uncle:	DOB/Age:	Whereabouts:	Historic Relationship/Connection with this Child:
Paternal Uncle:	DOB/Age:	Whereabouts:	Historic Relationship/Connection with this Child:

Other Family -- Name:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**
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Other Family -- Name:	**DOB/Age:**	**Whereabouts:**	**Historic Relationship/Connection with this Child:**

WAS ANYONE IN BIRTH MOTHER'S FAMILY ADOPTED:

BIRTH MOTHER'S RELATIONSHIP WITH HER PARENTS:

BIRTH MOTHER'S RELATIONSHIP WITH HER SIBLINGS:

BIRTH MOTHER'S RELATIONSHIP WITH HER EXTENDED FAMILY:

Additional Information/Summary:

Person Completing this Form: _____ Date Completed: _____

Person Completing this Form: _____ Date Completed: _____

Person Updating this Form: _____ Date Revised: _____

Person Updating this Form: _____ **Date Revised:** _____

BIRTH PARENT MEDICAL INFORMATION

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS WHICH ARE IN YOUR FAMILY HISTORY -- INCLUDE THE PERSON'S RELATIONSHIP TO YOU AND THEIR NAME

(This should include your parents, maternal and paternal grandparents, siblings, aunts, uncles, cousins, etc.)

MEDICAL CONDITIONS	RELATIONSHIP TO YOU	NAME OF PERSON W/CONDITION
☐ Alcoholism		
☐ Allergies (Specify type)		
☐ Cancer		
☐ Cerebral Palsy		
☐ Diabetes		
☐ Drug Addiction		
☐ Emphysema		
☐ Eye Problems		
☐ Heart Disease		
☐ Kidney Disease		
☐ Mental Health Issues		
☐ Multiple Sclerosis		
☐ Nervous Disorders		
☐ Obesity		

Please provide specific details of important medical information, including any deaths that resulted from the diseases in your family history: