Connecticut Department of Children and Families

MEDICAL INFORMATION ON GENETIC PARENT

DCF-338
1/19 (Rev.)

☐ Mother *(Use a separate form for each parent)* ☐ Father

Indicate by checking "Yes" or "No" if you or any genetic relatives (i.e. your mother, father, sisters, brothers, grandparents, aunts, uncles, or any other children you have had) ever had, or now have, the medical items listed. Also complete the "Comment" section.

Medical Condition	Self	Yes – Relative *(Specify which relative)*	Comments: *(Provide details incluaing, cause, age at onset, treatment and any hospitalizations)*
1. Club Foot	☐ No ☐ Yes ☐ Don't Know		
2. Harelip (Cleft Lip) or cleft palate	☐ No ☐ Yes ☐ Don't Know		
3. Congenital heart defect	☐ No ☐ Yes ☐ Don't Know		
4. Any other malformations	☐ No ☐ Yes ☐ Don't Know		
5. Muscular dystrophy	☐ No ☐ Yes ☐ Don't Know		
6. Multiple sclerosis	☐ No ☐ Yes ☐ Don't Know		
7. Cerebral palsy	☐ No ☐ Yes ☐ Don't Know		
8. Other paralysis or crippling disorder	☐ No ☐ Yes ☐ Don't Know		
9. Seizures, convulsions or epilepsy	☐ No ☐ Yes ☐ Don't Know		
10. Blindness, glaucoma or other visual problems	☐ No ☐ Yes ☐ Don't Know		
11. Deafness or other ear problems	☐ No ☐ Yes ☐ Don't Know		
12. Speech problem	☐ No ☐ Yes ☐ Don't Know		
13. Learning disability	☐ No ☐ Yes ☐ Don't Know		
14. Developmental disability: mental or physical	☐ No ☐ Yes ☐ Don't Know		
15. Diabetes	☐ No ☐ Yes ☐ Don't Know		
16. Thyroid disorder	☐ No ☐ Yes ☐ Don't Know		
17. Other hormone disorder	☐ No ☐ Yes ☐ Don't Know		
18. Eczema or other skin conditions	☐ No ☐ Yes ☐ Don't Know		
19. Asthma	☐ No ☐ Yes ☐ Don't Know		
20. Hay fever or other allergy	☐ No ☐ Yes ☐ Don't Know		
21. Hemophilia	☐ No ☐ Yes ☐ Don't Know		
22. Sickle cell anemia	☐ No ☐ Yes ☐ Don't Know		
23. Other blood disease, including anemia	☐ No ☐ Yes ☐ Don't Know		
24. Schizophrenia	☐ No ☐ Yes ☐ Don't Know		
25. Manic depressive	☐ No ☐ Yes ☐ Don't Know		
26. Other mental or emotional illness	☐ No ☐ Yes ☐ Don't Know		
27. Hypertension (high blood pressure)	☐ No ☐ Yes ☐ Don't Know		
28. Stroke	☐ No ☐ Yes ☐ Don't Know		
29. Heart attack (Coronary)	☐ No ☐ Yes ☐ Don't Know		
30. Other Cardiovascular Problems	☐ No ☐ Yes ☐ Don't Know		
31. Cancer	☐ No ☐ Yes ☐ Don't Know		
32. Tumors	☐ No ☐ Yes ☐ Don't Know		
33. Cystic fibrosis	☐ No ☐ Yes ☐ Don't Know		
34. Huntington's disease	☐ No ☐ Yes ☐ Don't Know		
35. Tuberculosis	☐ No ☐ Yes ☐ Don't Know		
36. Kidney disease	☐ No ☐ Yes ☐ Don't Know		
37. Alcoholism or heavy drinking	☐ No ☐ Yes ☐ Don't Know		
38. Drug usage	☐ No ☐ Yes ☐ Don't Know		
39. Hospitalization, operation, or injury	☐ No ☐ Yes ☐ Don't Know		
40. Any other condition you or others in your family might have	☐ No ☐ Yes ☐ Don't Know		

If "yes", please describe:

Initial: Adoptive Parent 1:

Initial: Adoptive Parent 2:

THIS SECTION FOR GENETIC MOTHER ONLY		MENSTRUAL AND PREGNANCY HISTORY	
Age at onset of menses:	Usual Length of Period:	Regular? ☐ Yes ☐ No	Number of Days between:

Please list all your pregnancies in order. (Use one line for each child or for each miscarriage, abortion, or still birth.)

Children: (write: boy, girl, abortion, miscarriage, or still-birth)	How Many Months Did You Carry This Pregnancy?	Year in Which Pregnancy Ended	If Miscarriage or Abortion, Was it Natural or Induced?

CURRENT PREGNANCY

Is the baby's father aware of this pregnancy? ☐ Yes ☐ No ☐ Not Sure	Is the baby's father a genetic relative of yours? ☐ Yes ☐ No If "Yes", how is he related?
What month did prenatal care begin for this baby?	Any Complications?

Any exposure during this pregnancy? ☐ X-ray ☐ Electrocardiogram ☐ Radiation

DRUGS TAKEN DURING PREGNANCY

List Prescription Drugs, frequency and dosages:

List Non-Prescription Drugs frequency and dosages (including aspirin and/or nose drops) When and frequency during pregnancy

SUBSTANCE:	Yes/No	If "Yes", What kind?:	Amount?:	How Often?:
Alcohol	☐ Yes / ☐ No			
Amphetamines *(Uppers)*	☐ Yes / ☐ No			
Barbiturates *(Downers)*	☐ Yes / ☐ No			
Cigarettes	☐ Yes / ☐ No			
Cocaine	☐ Yes / ☐ No			
Heroin	☐ Yes / ☐ No			
LSD	☐ Yes / ☐ No			
Marijuana	☐ Yes / ☐ No			
Opioids	☐ Yes / ☐ No			
Other:	☐ Yes / ☐ No			

BIRTH HISTORY

Child's Name:	DOB:	Time:	Gender:	Weight: lbs oz

Term: ☐ Premature ☐ Full ☐ Postmature	Pregnancy occurred at (# of Weeks):	Head Circumference	Chest Circumference

Any Abnormalities:

Mother's Blood Type	Rh Factor:	Baby's Blood Type:
Duration of Labor:	Anesthesia Used:	
Type of Delivery:	Apgar score at 1 and 5 minutes:	Condition of Child at Birth:

CHILD's MEDICAL HISTORY

First Tooth at *(months):*	Sat Alone at *(months):*	Walked at *(months):*	Convulsive Disorder *(month and year noted)*
Toilet Trained at *(months):*	Diagnosed Medical Conditions *(i.e., allergies, asthma, bronchitis, etc.):*		

Attach Medical Passport and Do Not Complete if Immunizations, Diseases and Hospitals Information are Contained on Passport

IMMUNIZATIONS	Original Date:	Booster Date:	Booster Date:	Booster Date:
DPT				
Small Pox				
Polio				
Other:				
Measles				
Mumps				
Rubella				
Chicken Pox				
Whooping Cough				
Other:				

Comments:

HOSPITALIZATIONS

Any Hospitalizations? (Reason, Date(s) and Place(s):

EVALUATIONS / EXAMINATIONS

Please complete the following Type of Tests:	Date	Performed by:
Psychological Evaluations		
Psychiatric Evaluation		
Intellectual Assessment		
Developmental Evaluation *(Includes :Speech, Language, Hearing)*		
Physical Examination		
Neurological Evaluation		
OTHER:		

I hereby acknowledge receipt of a copy of this form.	Signature of Adoptive Parent 1:	Date:
	Signature of Adoptive Parent 2:	Date:

Name of Agency:			
Address (No. and Street)	City:	State:	Zip:
Agency Representative Name:	Agency Representative Signature		Date