Connecticut Department of Children and Families
MEDICAL INFORMATION ON GENETIC PARENT
DCF-Probate-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 including, 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<br>If "Yes", how is he related? |
| What month did prenatal care begin for this baby? Select Month | 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 | | | Select One |
| Amphetamines *(Uppers)* | ☐ Yes / ☐ No | | | Select One |
| Barbiturates *(Downers)* | ☐ Yes / ☐ No | | | Select One |
| Cigarettes | ☐ Yes / ☐ No | | | Select One |
| Cocaine | ☐ Yes / ☐ No | | | Select One |
| Heroin | ☐ Yes / ☐ No | | | Select One |
| LSD | ☐ Yes / ☐ No | | | Select One |
| Marijuana | ☐ Yes / ☐ No | | | Select One |
| Opioids | ☐ Yes / ☐ No | | | Select One |
| Other: | ☐ Yes / ☐ No | | | Select One |

**BIRTH HISTORY**

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

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

Any Abnormalities:

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

| CHILD's MEDICAL HISTORY | | | |
|---|---|---|---|
| First Tooth at *(months):* Select ( | Sat Alone at *(months):* Select ( | Walked at *(months):* Select ( | Convulsive Disorder *(month and year noted)* |
| Toilet Trained at *(months* Select ( | 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 |