



Biological Mother Medical, Social and Family History

PLEASE CHECK ONE BOX BELOW

- I give permission to forward ALL information to the prospective adoptive family.
- I would prefer that all identifying information (names, addresses and Social Security Number) be deleted before forwarding to the prospective adoptive family.



Friends in Adoption

653 Plank Road, Suite 200
Clifton Park, NY 12065

1-800-98-ADOPT (1-800-982-3678)

Fax (518) 371-9936

www.friendsinadoption.org

The attached form is designed to gather medical, social and family background information from you.

This medical, social and family information will be passed on to the prospective adoptive family with whom you have chosen to work. Please know that completing this form is in no way a commitment to adoption. If you have any questions about information requested in this form, please call Friends in Adoption at 1.800.98.ADOPT (1.800.982.3678). If you cannot answer a question, you may leave it blank.

Should you place your child for adoption, this information will prove to be very helpful to the adoptive family in parenting your child. It is important that they have this information so it can then become a part of their family history. Many health conditions are hereditary and can be passed on to your child. This information may also be important when the child begins to ask specific questions about his or her biological parents (i.e., names, interests, talents, appearances, and health). Answers will then be readily available. If possible, would you please include a picture of yourself and, if applicable, your family also.

For these reasons, please answer these questions to your comfort level so that your child will have a clearer understanding of his or her background. As information changes, you may update the information by calling or writing to Friends in Adoption.

Again, this form is in no way a commitment to adoption, but it is important in order to proceed with your adoption plan.

Thank you.

PLEASE PRINT ALL INFORMATION



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BIOLOGICAL MOTHER

Hobbies/Interests/Talents: _____

Future Plans: _____

Personality: _____

Height: _____ Normal Weight: _____ Hair Color: _____ Eye Color: _____

Complexion: _____ General Build: _____

Are you right-handed or left-handed? _____

Race: _____ Ethnic Background: _____

American Indian: Yes No *IMPORTANT: If YES, please complete the following:

Name of person registered: _____ Birth date: _____

Tribe Name: _____ Tribe Location: _____

Important! If you or a member of your family are registered with an American Indian Tribe, this is important information for us to know ahead of time in order to help your adoption go smoothly.



BIOLOGICAL FATHER

If the father is uninvolved and you haven't consulted an attorney, leave this section blank.

Name of the Biological Father: _____

Address: _____

Phone Number: _____

Is the father of this child aware of your pregnancy/adoption plans? Yes No

If so, is he supportive? Yes No

What is your relationship now? _____

Are family members aware of your pregnancy/adoption plans? Yes No

If so, are they supportive? Yes No

PREGNANCY

When is your due date? _____

What will the race of your baby be? _____

What will your baby's ethnic background be? _____

Are you receiving pre-natal care? Yes No

If so, in what month did you begin? _____

Did you have alcohol during this pregnancy? Yes No

If so, how many drinks did you have at one time, how often and when during your pregnancy? _____

Did you take any prescription drugs, over-the-counter medication or street drugs during your pregnancy? Yes No

If so, what kind and how often? _____

Did you smoke during the pregnancy? Yes No If so, how much? _____

Do you have any pregnancy related problems? (i.e. high blood pressure, diabetes, excessive bleeding, kidney or bladder infections?) _____



YOUR THOUGHTS ON ADOPTION

Are you adopted? Yes No

Have you made an adoption plan before? Yes No

Is anyone in your family adopted? Yes No If yes, who and what is their relationship to you? _____

Do you have friends who are adopted? Yes No

Do you have friends/family who have made an adoption plan for their child? Yes No

Would you like future contact with your baby or the adoptive family? Yes No

If yes, please describe the type of contact (i.e. letters, pictures, telephone contact, visits): _____

Why is this adoption being planned for your child? _____

Feelings/Comments about placing a child for adoption: _____

Desires for child: _____

Would you like to: Select the adoptive family? Yes No Not sure

Talk on the phone with the adoptive family? Yes No Not sure

Meet the adoptive family? Yes No Not sure

Would you be willing to be contacted during your child's minority if a health problem arises for the child which necessitates either

ADOPTIVE FAMILY PREFERENCES WORKSHEET

If you choose adoption, what sort of parent(s) would you like your child to have? This worksheet may help you determine what you are looking for in an adoptive family. Check the box that most closely fits your wishes.

	Essential	Important	Fine With Me	Prefer Not	Definitely Not
Married					
Single					
Non-Traditional Couple					
Other child(ren) already in family					
Over the age of 30					
Financially Stable					
College Educated					
Religious Preference (please write in religion if important to you)					
Live in a rural or semi-rural environment					
Enjoy/spend time in the outdoors					
Involved with extended family					
Non-smokers					
Currently living in: NY, VT, RI, CT, MA, NH, NJ					
Parent of the same race as the child					
Post-Adopt Contact: Letters					
Post-Adopt Contact: Visits					

Child of Biological Mother: If you have any other children, please fill in the chart below:

	Child 1	Child 2	Child 3
Full Name			
Date of Birth			
Sex			
Hair Color			
Eye Color			
Build			
Complexion/Skin Color			
Behavior/Development			

Siblings of Biological Mother: If you have any siblings, please fill in the chart below:

	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Full Name				
Age				
Height				
Weight				
Hair Color				
Eye Color				
Education (highest grade level completed)				
Occupation				
Interests/Talents				

Parents of Biological Mother: Please fill in the information for *your* biological parents in the chart below:

	Your Mother	Your Father
Full Name (include middle & maiden)		
Age		
Height		
Weight		
Hair Color		
Eye Color		
General Build		
General Health (if deceased, please include age and cause of death)		
Race		
Nationality/Ethnic Background		
Education (highest grade completed)		
Occupation		
Interests/Talents		

YOUR RELATIVES

Grandparents of Biological Mother: Please fill in the information for *your* biological grandparents in the chart below:

	Your Mother's Mother	Your Mother's Father	Your Father's Mother	Your Father's Father
Full Name (include middle & maiden)				
Age				
Hair Color				
Eye Color				
General Build				
General Health (if deceased, please include age and cause of death)				
Nationality/ Ethnic Background				
Occupation				
Interests/Talents				

BIOLOGICAL MOTHER HEALTH HISTORY, MEDICAL CONDITIONS, DISEASES, AND ILLNESSES:

Medical Condition	Mother		Relative	
	YES	NO	Relationship to Mother – Specify	Additional Information
Arthritis				
Rheumatoid				
Osteo				
Juvenile				
Birth Handicaps				
Cleft palate				
Harelip				
Congenital Heart Defect				
Fetal Alcohol Syndrome				
Fetal Drug Exposure				
Hydrocephalus				
Microcephalus				
Spina Bifida				
Cancer				
Breast				
Cervical				
Uterine				
Ovarian				
Hodgkin's Disease				

Medical Condition	Mother		Relative	
	YES	NO	Relationship to Mother – Specify	Additional Information
Cancer (continued)				
Bone				
Prostate				
Lung				
Melanoma (Skin)				
Stomach				
Liver				
Malignant Tumors				
Benign Tumors				
Blood Problems				
Anemia				
Cooley's Anemia (Thalassemia)				
Hemophilia				
Leukemia				
Addison's Disease				
Sickle Cell Trait				
Sickle Cell Disease				
Hepatitis				
Cardiac Conditions				
Arteriosclerosis				
High Blood Pressure				
Hypertension				
Murmur				
Mitral valve prolapse				
Angina				
Stroke				
Heart Attack				
Chromosomal Abnormalities				
Down's Syndrome				
Turner's Syndrome				
Dental Conditions				
Periodontal disease				
Gingivitis				
Overbite				

Medical Condition	Mother		Relative	
	YES	NO	Relationship to Mother – Specify	Additional Information
Dental Conditions (con't.)				
Underbite				
Dentures				
Multiple cavities				
Educational Handicaps				
Mental Retardation				
Attention Deficit Disorder				
Hyperactivity				
Hearing Impaired (specify)				
Speech Problems (specify)				
Learning Disorder (specify)				
Mental Health				
Depression				
Autism				
Alzheimer's Disease				
Suicidal				
Psychosis				
Schizophrenia				
Manic Depressive				
Anorexia				
Bulimia				
Musculoskeletal Conditions				
Cerebral Palsy				
Clubfoot				
Scoliosis				
Slipped disk				
Pinched nerve				
Respiratory Conditions				
Asthma				
Emphysema				
Cystic Fibrosis				
Allergies/Hay Fever				
Food Allergies				

Medical Condition	Mother		Relative	
	YES	NO	Relationship to Mother – Specify	Additional Information
Respiratory Cond. (con't.)				
Drug Allergies				
Reactive Airway Disease				
Tuberculosis				
Sexually Transmitted Diseases				
Gonorrhea				
Chlamydia				
Syphilis				
HIV Positive				
Herpes				
Pelvic Inflammatory Disease				
Skeletal Abnormalities				
Dwarfism				
Hunchback				
Easily Broken Bones				
Osteoporosis				
Malformed Features or Organs (specify)				
Paralysis				
Abnormal Digits (specify)				
Skin Conditions				
Psoriasis				
Eczema				
Seborrhea				
Visual Conditions				
Blindness				
Retinitis Pigmentosa				
Glaucoma				
Near Sighted				
Far Sighted				
Color Blindness				
Crossed Eyes				
Lazy Eyes				
Cataracts				
Astigmatism				

Medical Condition	Mother		Relative	
	YES	NO	Relationship to Mother – Specify	Additional Information
Other Illnesses				
Epilepsy/Seizures				
Tourettes Syndrome				
Crohn's Disease				
Lyme Disease				
Hepatitis (specify)				
Thyroid Disease/Disorder				
Cirrhosis				
Diabetes				
Kidney Stones				
Endometriosis				
Gall Stones				
Lupus				
Kidney Disease				
Liver Disease				
General Health Issues				
Hypoglycemia				
High Cholesterol				
Obesity				
Malnutrition				
Multiple Births				
Premature Babies				
SIDS				
Apnea Monitor				

Additional Comments: _____



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Medical Release

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PLEASE FILL OUT AND RETURN TO FRIENDS IN ADOPTION IN THE ENCLOSED ENVELOPE. THANK YOU.

Patient Name: _____ Date of Birth: _____

Social Security Number: _____

Medical Provider's Name: _____

Medical Provider's Address: _____

Medical Provider's Phone: _____ Medical Provider's Fax: _____

Dear Medical Provider:

I am considering making an adoption plan with Friends In Adoption ("FIA"). Please copy and forward my medical records to them at your earliest convenience. FIA will be happy to reimburse any copying costs. Thank you.

- I, _____ give my consent to have my medical records released and forwarded to Friends In Adoption. I also give FIA permission to forward these records to the prospective adoptive family, and all other relevant parties.
- I, _____ give my consent to have the results of my HIV test released and forwarded to Friends In Adoption. I also give FIA permission to forward these records to the prospective adoptive family, and all other relevant parties.
- I, _____ also authorize the release of my Medicaid/Insurance information to Friends In Adoption. I give FIA permission to release and forward this information to all relevant parties.
- I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to _____.
- I understand that revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire within six months after the birth of my baby.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect a copy of the information to be used or disclosed, as provided in CFR 167.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact _____.

This authorization is intended to constitute a release of privileged communication and a request for the cooperation of the above-named addressee. Consequently, you are authorized to discuss my medical condition and medical records with Friends In Adoption, in addition to providing them with the above described records and documents.

SIGNATURE OF PATIENT

DATE



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