Birth Parent Updated Medical History

OFFICIAL USE ONLY	
CERTIFICATE NUMBER	
DATE RECEIVED	
DATE ISSUED	

Please ***PRINT (in black ink only)*** and complete as many items as known, required items are marked (*required)

Name of Child on original birth record: ______________________

First name Middle name Last name (***REQUIRED**)

City/Town of Birth: Hospital:

Date of Birth: Sex: ☐ Female ☐ Male

Month Day Year (***REQUIRED)**

Mother's name (as shown on child's birth record)

Person completing this form is: ☐ Birth Mother ☐ Birth Father

Please indicate if information is unknown ("unk") or not available ("N/A").

MEDICAL CONDITIONS OF CHILD'S BIOLOGICAL FAMILY

Mother's Family and Father's Family
*Please list relationship to child; e.g., parent, grandparent, aunt, uncle, sibling.

Condition	Mother's Family*	Father's Family*	Comments (if condition resulted in death, note here)
1. Respiratory			
Allergies			
Asthma			
Bronchitis			
Emphysema			
Tuberculosis			
Cystic Fibrosis			
Other			
2. Gastrointestinal			
Ulcers			
Inflammatory Bowel			
Cleft lip or palate			
Other			
3. Cardiovascular			
High blood pressure			
Heart attack			
Stroke			
Congestive heart failure			
Atherosclerosis			
Heart rhythm abnormality			
Congenital heart defect			
Other			

Name of child on original birth record: ______________________________
DOB: ____ Certificate number: ______________________

Condition	Mother's Family*	Father's Family*	Comments (if condition resulted in death, note here)
4. Immune/Hematological			
Mononucleosis			
Hemophilia			
Leukemia			
Lymphomas			
Hodgkin's disease			
Other cancer (type?)			
5. Renal			
Kidney failure/ dialysis/transplant			
Other kidney problems			
6. Liver Disease			
Hepatitis (specify type)			
Cirrhosis			
Other liver disease			
7. Central Nervous System			
Epilepsy			
Hydrocephalus			
Multiple Sclerosis			
Huntington's Chorea			
Seizures/ convulsions			
Other			
8. Endocrine			
Diabetes (adult or juvenile) - list treatment			
Thyroid (hyper/hypo)			
Adrenal			
Other hormonal disorder			
9. Muscular/Skeletal			
Club foot			
Scoliosis (curvature of the spine)			
Arthritis (osteo or rheumatoid)			
Lupus			
Other paralysis or crippling disorder			

Name of child on original birth record: ______________________________
DOB: ____ Certificate number: ______________________

*Please list relationship to child; e.g., parent, grandparent, aunt, uncle, sibling. If additional space is needed, please attach a separate sheet when filing this form.

Condition	Mother's Family*	Father's Family*	Comments (if condition resulted in death, note here)
10. Neuromuscular			
Cerebral Palsy			
Muscular Dystrophy			
Spina Bifida			
Other			
11. Visual/Auditory/Speech			
Blindness			
Glaucoma			
Cataracts or other eye problems (specify)			
Deafness or other hearing problems (specify)			
Speech problems			
Other			
Other Conditions			
12. Mental Illness List type: (e.g., depression, bipolar, schizophrenia)			
13. Alcohol or drug abuse			
14. Eating disorders			
15. Learning disability			
16. Mental retardation			
17. Eczema or other skin conditions			
18. Give age at death and cause of death of child's grand-parent, aunt, uncle, and siblings (if applicable)	Grandmother	Grandmother	
	Grandfather	Grandfather	
	Aunt	Aunt	
	Uncle	Uncle	
	Sibling	Sibling	

*Please list relationship to child; e.g. parent, grandparent, aunt, uncle, sibling. If additional space is needed, please attach a separate sheet when filing this form.

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Drug and Alcohol Use During Pregnancy	Mother's Family	Father's Family	Comments Kind taken, when, amount and frequency (where applicable)
Prescription drugs taken during pregnancy			
Non-prescription drugs taken during pregnancy			
Alcohol use during pregnancy			
Marijuana use during pregnancy			
Amphetamines used during pregnancy			
Barbiturates used during pregnancy			

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Information on this Pregnancy

Was adoptee's father aware of this pregnancy? ☐ Yes ☐ No

Was birth mother exposed during pregnancy to the following? ☐ X-Ray ☐ Electrocardiogram ☐ Radiation

☐ Other (please specify) ____

Did birth mother have prenatal care? ☐ Yes ☐ No

If yes, in what month did prenatal care begin? ______________________________

Were there any complications? ☐ Yes ☐ No If yes, please specify. ______________________

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Name of child on original birth record: ______________________________
DOB: _______________________________________ Certificate number: ______________________

OTHER INFORMATION ON BIRTH PARENTS

Information given should be at time of child's birth. DO NOT include identifying information.

Mother's Information		
Height	Weight	Body shape/build
Eye color	Hair color	Skin color
Age	Ethnic background	Nationality (citizenship)
Religion	Number of school years completed	RH factor
Blood type ☐ O ☐ A ☐ B ☐AB	Race ☐ White ☐ Black ☐American Indian/Alaskan Native ☐Other	☐ Asian ☐ Native Hawaiian or other Pacific Islander
Father's Information		
Height	Weight	Body shape/build
Eye color	Hair color	Skin Color
Age	Ethnic background	Nationality (citizenship)
Religion	Number of school years completed	RH factor
Blood type ☐ O ☐ A ☐ B ☐AB	Race ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Other	☐ Asian ☐ Native Hawaiian or other Pacific Islander

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Please return this completed form to:

Maine Department of Health and Human Services
Office of Vital Records
244 Water Street #11 SHS
Augusta, Maine 04333-0011
(207) 287-1919
TTY 1-800-606-0215