

Family Life Services
P.O. Box 4199
Lynchburg, Virginia 24502

Social and Medical History-Birth Father

Full Name: _____

Current Address: _____

Permanent Address (if different): _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Date of Birth: _____ Place of Birth: _____

Social Security #: _____ Driver's License Number: _____

| | | | |
|-------------------|--|-------------------------|--|
| Age | | Race | |
| Height | | Religion | |
| Weight | | Marital Status | |
| Complexion | | Education | |
| Eye Color | | Occupation | |
| Hair Color | | Military Service | |

| | | | |
|--|-------|----|-----|
| Are you a citizen of the United States? | Yes | No | |
| Are you a permanent resident (with a green card) of the United States? | Yes | No | N/A |
| Do you have a passport or visa number? | _____ | | |

Describe your Personality: _____

Do you have children? Yes _____ No _____ How Many? _____

| Child's Name | Date of Birth | Birth Weight | Delivery Type | Duration of Labor | Born Early, on Time, Or Late | Birth Defects | Who is Parenting this Child? |
|--------------|---------------|--------------|---------------|-------------------|------------------------------|---------------|------------------------------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Your Birth History:

Your weight at birth: _____ Your length at birth: _____

Any complications? _____

Health History of Birth Father and Family:

Place an "X" if the listed medical condition exists in your medical history or if you, your grandparents, parents, siblings, or children have/had any of the conditions. If one of your family member's deaths was the result of a particular medical condition, note it on the comments section to the right of the condition and write the age at which they died. Please only include biological family members.

| | You | Your Mother | Your Father | Your Siblings | Your Children | Indicate type, area affected, age onset, treatments, etc. |
|-------------------------------------|-----|-------------|-------------|---------------|---------------|---|
| Seasonal Allergies | | | | | | |
| Food Allergies | | | | | | |
| Drug Allergies | | | | | | |
| Other Allergies | | | | | | |
| Cancer | | | | | | |
| Diabetes | | | | | | |
| Brain Tumor | | | | | | |
| Intellectual Disability | | | | | | |
| Down's Syndrome | | | | | | |
| Turner's Syndrome | | | | | | |
| Hydrocephalus | | | | | | |
| Microcephalus | | | | | | |
| Other Developmental Disorders | | | | | | |
| Obsessive Compulsive Disorder (OCD) | | | | | | |
| Diagnosed Schizophrenia | | | | | | |
| Diagnosed Bipolar | | | | | | |
| Borderline Personality Disorder | | | | | | |
| Serious Depression | | | | | | |
| Diagnosed Manic Depressive | | | | | | |
| Suicide/Attempted Suicide | | | | | | |

| | You | Your Mother | Your Father | Your Siblings | Your Children | Indicate type, area affected, age onset, treatments, etc. |
|-------------------------------|-----|-------------|-------------|---------------|---------------|---|
| Other Mental Disorders | | | | | | |
| Other Behavioral Disorders | | | | | | |
| Alcoholism or Heavy Drinking | | | | | | |
| Drug Use | | | | | | |
| Lymphoma | | | | | | |
| Neuro Tube Defect | | | | | | |
| Fetal Alcohol Syndrome | | | | | | |
| Ambiguous Genitalia | | | | | | |
| Osteoporosis | | | | | | |
| Colitis | | | | | | |
| Apnea Monitor | | | | | | |
| Bed Wetting | | | | | | |
| Wilson's Disease | | | | | | |
| Trisomy | | | | | | |
| Gout | | | | | | |
| Sickle Cell Anemia or Trait | | | | | | |
| Cystic Fibrosis | | | | | | |
| Club Foot/Orthopedic Problems | | | | | | |
| Cleft Lip/Cleft Palate | | | | | | |
| Cerebral Palsy | | | | | | |
| Muscular Dystrophy | | | | | | |
| Dwarfism | | | | | | |
| Spina Bifida | | | | | | |
| Congenital Heart Defect | | | | | | |
| Tuberculosis | | | | | | |

| | You | Your Mother | Your Father | Your Siblings | Your Children | Indicate type, area affected, age onset, treatments, etc. |
|---------------------------------|-----|-------------|-------------|---------------|---------------|---|
| Nearsighted | | | | | | |
| Farsighted | | | | | | |
| Astigmatism | | | | | | |
| Different color eyes | | | | | | |
| Night/Color Blindness | | | | | | |
| Glaucoma | | | | | | |
| Blindness | | | | | | |
| Strabismus (cross eye) | | | | | | |
| Cataracts/Other Vision Problems | | | | | | |
| Sinus or Nasal Problems | | | | | | |
| Ear Infections | | | | | | |
| Deafness | | | | | | |
| Dental Problems | | | | | | |
| Gum Disease | | | | | | |
| Speech Problems | | | | | | |
| Dyslexia | | | | | | |
| Autism | | | | | | |
| Hyperactivity ADHD/ADD | | | | | | |
| Learning Disability | | | | | | |
| Hypertension | | | | | | |
| Heart Murmurs | | | | | | |
| Mitral Valve Prolapse | | | | | | |
| Heart Attack | | | | | | |
| Hemophilia | | | | | | |
| Stroke | | | | | | |
| Congestive Heart Defect | | | | | | |

| | You | Your Mother | Your Father | Your Siblings | Your Children | Indicate type, area affected, age onset, treatments, etc. |
|--------------------------------------|-----|-------------|-------------|---------------|---------------|---|
| Anemia | | | | | | |
| Heart Surgery | | | | | | |
| Blood Disorder | | | | | | |
| Alzheimer's Disease | | | | | | |
| Eczema/Acne/ Other skin condition | | | | | | |
| Hives | | | | | | |
| Atherosclerosis | | | | | | |
| Mononucleosis | | | | | | |
| Jaundice | | | | | | |
| Cirrhosis | | | | | | |
| Other Liver Problems | | | | | | |
| Scoliosis | | | | | | |
| Back Problems | | | | | | |
| Arthritis | | | | | | |
| Lupus | | | | | | |
| Rheumatic Fever | | | | | | |
| Atrial Fibrillation | | | | | | |
| Irregular Heart Beat | | | | | | |
| Other Heart Problems | | | | | | |
| Asthma | | | | | | |
| Chronic Bronchitis | | | | | | |
| Sudden Infant Death Syndrome | | | | | | |
| Pneumonia | | | | | | |
| Reactive Airway Disease | | | | | | |
| Angina | | | | | | |
| Other Respiratory Problems | | | | | | |

| | You | Your Mother | Your Father | Your Siblings | Your Children | Indicate type, area affected, age onset, treatments, etc. |
|--------------------------------|-----|-------------|-------------|---------------|---------------|---|
| Ulcers | | | | | | |
| Gall Bladder Problem | | | | | | |
| High Cholesterol | | | | | | |
| Obesity | | | | | | |
| Anorexia/Bulimia | | | | | | |
| Other Digestive Disorders | | | | | | |
| Bladder Problems | | | | | | |
| Kidney Failure | | | | | | |
| Kidney Transplant | | | | | | |
| Kidney Stones | | | | | | |
| Multiple Sclerosis | | | | | | |
| Lou Gehrig's Disease | | | | | | |
| Seizures or Convulsions | | | | | | |
| Huntington's Disease | | | | | | |
| Parkinson's Disease | | | | | | |
| Epilepsy | | | | | | |
| Tourette's Syndrome | | | | | | |
| Crohn's Disease | | | | | | |
| Lyme Disease | | | | | | |
| Migraine Headaches | | | | | | |
| Other Nervous System Disorders | | | | | | |
| Arthritis | | | | | | |
| Hodgkin's Disease | | | | | | |
| Cysts/Lumps/Growths | | | | | | |

| | You | Your Mother | Your Father | Your Siblings | Your Children | Indicate type, area affected, age onset, treatments, etc. |
|--|-----|-------------|-------------|---------------|---------------|---|
| Emphysema | | | | | | |
| Chromosome Abnormality | | | | | | |
| Tay-Sachs Disease | | | | | | |
| Birthmarks | | | | | | |
| Pyloric Stenosis (projectile vomiting) | | | | | | |
| Neurofibromatosis | | | | | | |
| Meningitis | | | | | | |
| HIV/AIDS | | | | | | |
| | | | | | | |
| | | | | | | |

Please list any hospitalizations you have had including dates and reasons for hospitalization:

Please list any other medical issue within your family that was not covered above: _____

Mental Health History of Birth Father:

Have you ever received a mental health diagnosis? _____

If yes, please describe _____

Have you ever gone to a psychologist, psychiatrist, clinical social worker, mental health or behavioral health therapist for any emotional, psychological, or behavioral problems? Yes No

Dates/Reasons: _____

Name and location of therapist/agency: _____

Indicate medications prescribed during treatment: _____

Reason for discontinued treatment: _____

Please list any hospitalizations for psychiatric treatment: _____

Please list any other mental health issue within your family that was not covered above:

Social History of Birth Father's Parents and Siblings:

Please answer to the best of your ability. If you do not know the answer, leave it blank.

If you have additional siblings, please list them on a separate sheet of paper.

| | Your Mother | Your Father | Your Brother/Sister#1 | Your Brother/Sister #2 |
|--|-------------|-------------|-----------------------|------------------------|
| Name | | | | |
| Please Specify Relationship: ie. Biological, Half, Step, Adopted | | | | |
| Age Or Year Of Birth | | | | |
| Race | | | | |
| Ethnic Origin | | | | |
| Height | | | | |
| Eye Color | | | | |
| Hair Color | | | | |
| Religion | | | | |
| Marital Status | | | | |
| Military Service | | | | |
| Education Level | | | | |
| Occupation | | | | |
| Interests | | | | |
| Marital Status | | | | |

If you have any siblings, are you a twin or triplet? Yes No

If yes, are you identical or fraternal? _____

Social History of Birth Father's Grandparents:

Please answer to the best of your ability. If you do not know the answer, leave it blank.

| | Your Mother's Mother | Your Mother's Father | Your Father's Mother | Your Father's Father |
|----------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| Name | | | | |
| Age or Year of Birth | | | | |
| Race | | | | |
| Ethnic Origin | | | | |
| Height | | | | |
| Eye Color | | | | |
| Hair Color | | | | |
| Religion | | | | |
| Marital Status | | | | |
| Military Service | | | | |
| Education Level | | | | |
| Occupation | | | | |
| Interests | | | | |
| Marital Status | | | | |

The above information is true and complete to the best of my knowledge.

Birth Father Signature: _____ **Date:** _____

Caseworker Signature: _____ **Date:** _____

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Native American-Indian Tribal Membership-Birth Father

1. Is there any American Indian heritage in your family? Yes No

If yes, please describe the blood relation and tribe (e.g. my mother was one-half Cherokee, my paternal grandfather was one-fourth Sioux). _____

2. Are you a member of any Native American Indian tribe? Yes No

3. Do you qualify to be a member of any Native American Indian tribe? Yes No

If yes, please indicate the tribe, location and your registration, enrollment, or registration number: _____

4. Are any of your relatives members of any Native American Indian tribes?

Yes No

5. Do any of your relatives qualify to be members of any Native American Indian tribes?

Yes No

If yes, please list the relative's name (including maiden or former names), address, registration/enrollment number, and the name and location of the tribe:

Birth Father

Date