Family Life Services

P.O. Box 4199
Lynchburg, Virginia 24502

Social and Medical History-Birth Mother

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		**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?

Have you ever had a miscarriage? Yes_____ No_____

How many? _____ Date: _____ How far along were you? _____

Have you ever had an abortion? Yes_____ No_____

How many? _____ Date: _____ How far along were you? _____

During This Pregnancy:

When did prenatal care begin? _____ Doctor's name: _____

Name of practice: _____

Have you had any of the following during this pregnancy?

	No	Yes	Indicate type, treatments, etc.
German Measles			
Sexually Transmitted Diseases			
Virus			
Infections			
Accidents			
Operations			

Please list and explain any other complications during this pregnancy: _____

_____

Medications or Substances Taken During this Pregnancy:

	Not taken	Used occasionally (1-5 times)	Used monthly during pregnancy	Used weekly during pregnancy	Used daily during pregnancy
Prenatal Vitamins					
Aspirin					
Ibuprofen					
Antibiotics					
Antihistamines					
Hormones					
Cortisone					
Diet Pills					
Sleeping Pills					
Medicine for Cancer					
Heart/Blood Pressure Pills					
Thalidomide					
Nausea Medicine					
Vitamin A					
Vitamin D					
Vitamin E					
Nose Drops					

	Not taken	Used occasionally (1-5 times)	Used monthly during pregnancy	Used weekly during pregnancy	Used daily during pregnancy
Alcoholic Beverages					
Cigarettes or Other Nicotine Product					
Amphetamines					
Barbiturates					
Cocaine/Crack					
Heroin					
LSD					
Marijuana					
Morphine					
Methamphetamine (Meth)					
Opium					
Bath Salts					
Oxycodone or "pain pills"					
Other?					

Marital History: If yes to either, fill out Marital History Form.

Are you currently married? Yes _____ No _____

Have you been married previously? Yes _____ No _____

Your Birth History:

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

Were you born (Circle One): Early On Time Late

Delivery Method: Vaginal delivery (normal) Caesarian (C-section)

Any complications? _____

_____

Your Menstrual History (Period History):

Age of onset: _____

Circle the word that best describes your cycles: Regular Irregular

Health History of Birth Mother 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						

	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						
Gynecological Problems						
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						

	You	Your Mother	Your Father	Your Siblings	Your Children	Indicate type, area affected, age onset, treatments, etc.
Tuberculosis						
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						

	You	Your Mother	Your Father	Your Siblings	Your Children	Indicate type, area affected, age onset, treatments, etc.
Other Respiratory Problems						
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.
Endometriosis						
Thyroid Disorder						
Menstrual Problems						
Problem Pregnancies						
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

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 Mother'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				
Address				
Phone Number				
Age Or Year Of Birth				
Race				
Ethnic Origin				
Height				
Eye Color				
Hair Color				
Religion				
Marital Status				
Military Service				
Education Level				
Occupation				
Interests				

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

If yes, are you identical or fraternal? _____

Social History of Birth Mother'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				
Address				
Phone Number				
Age or Year of Birth				
Race				
Ethnic Origin				
Height				
Eye Color				
Hair Color				
Religion				
Marital Status				
Military Service				
Education Level				
Occupation				
Interests				

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

Birth Mother Signature: _____Date: _____

Caseworker Signature: _____ Date: _____