

# **Pennsylvania's Adoption Medical History Registry**

## *Birth Parent Registration Form*



Edward G. Rendell  
*Governor*

Estelle B. Richman  
*Secretary*

*Return completed form to:*  
**ADOPTION MEDICAL HISTORY REGISTRY**  
**DPW/OCYF**  
**P.O. Box 2675**  
**Harrisburg, PA 17105-2675**

The Department of Public Welfare administers the Adoption Medical History Registry. The Registry allows birth parents of Pennsylvania-born adoptees to share, voluntarily and confidentially, family medical information with the child they placed for adoption or with the family who adopted their child.

A parent who gave birth in Pennsylvania and released that child for adoption may complete the Birth Parent Registration form. With notarized documentation of incapacity or death of a birth parent, other family members may submit information on his or her behalf. The medical history information maintained by the Registry will be released only to adoptees 18 years of age and older who were born in Pennsylvania or to parents or legal guardian who have adopted children under 18 years of age who were born in Pennsylvania.

If you choose to submit your medical history information, you can be confident that no identifying information about you will be released.

Forms may be submitted at any time to update medical history information. Forms are available by calling 800-227-0225 or by writing to the agency at: Medical History Registry, DPW/OCYF, P.O. Box 2675, Harrisburg, PA 17105-2675.

Forms also are available at any of the following locations: county children and youth agency offices; county court of common pleas; and licensed adoption agency offices.

## **RELATIONSHIP TO BIRTH PARENT**

Please indicate whether blood relatives are related to YOU through your mother or through your father.

If one of the relatives listed below is related to YOU through your **MOTHER**, that person is a **MATERNAL** relative.

If one of the relatives listed below is related to YOU through your **FATHER**, that person is a **PATERNAL** relative.

These family members fall into both a maternal and paternal category:

- Grandmother
- Grandfather
- Aunt
- Uncle
- Niece
- Nephew



**SECTION 4: GYNECOLOGY/PREGNANCY HISTORY (CONTINUED)**

11. DISEASES DURING PREGNANCY:  YES  NO IF YES, LIST BELOW:

DISEASE	TREATMENT
1.	
2.	

12. LENGTH OF PREGNANCY:  
 PREMATURE: NUMBER OF WEEKS EARLY \_\_\_\_\_  FULL-TERM  POST-TERM NUMBER OF WEEKS LATE \_\_\_\_\_

13. TOBACCO USE DURING PREGNANCY:  YES  NO IF YES, AVERAGE NUMBER OF CIGARETTES DAILY: \_\_\_\_\_

14. ALCOHOL USE DURING PREGNANCY:  YES  NO IF YES, AVERAGE NUMBER OF DRINKS WEEKLY: \_\_\_\_\_

15. LIST OVER-THE-COUNTER, PRESCRIPTION, LEGAL AND ILLEGAL DRUGS TAKEN DURING PREGNANCY:

1.	4.	7.
2.	5.	8.
3.	6.	9.

16. DURATION OF LABOR: \_\_\_\_\_ HRS. 17. TYPE OF DELIVERY:  
 SPONTANEOUS  BREECH  FORCEPS  CAESAREAN

18. COMPLICATIONS DURING DELIVERY:  YES  NO IF YES, DESCRIBE:

**SECTION 5: FAMILY MEDICAL HISTORY**

**INSTRUCTIONS:** This section applies only to the birth parent who is completing this form and his or her blood relatives.

- Check SELF if medical condition applies to the birth parent.
- Check FAMILY if medical condition applies to a blood relative of the birth parent.
- When FAMILY is checked, complete RELATIONSHIP TO BIRTH PARENT column.  
List relatives as described below:
  - **Relatives of the first degree:** mother, father, brother, sister, half brother, half sister, son or daughter; and
  - **Other blood relatives:** grandmother, grandfather, aunt or uncle. Each should be identified as being either a maternal (from your mother's family) or paternal (from your father's family) relative. *Example:* An aunt who is the sister of the birth parent's mother is the maternal aunt.

MEDICAL CONDITION (Check all that apply)	S E L F	F A M I L Y	RELATIONSHIP TO BIRTH PARENT
<b>A. ALLERGIES</b>			
1. Environmental			
a. plant			
b. animal			
2. Food			
3. Drug/Chemical			
4. Other (Specify)			
<b>B. EAR &amp; EYE CONDITIONS</b>			
1. Cataracts			

MEDICAL CONDITION (Check all that apply)	S E L F	F A M I L Y	RELATIONSHIP TO BIRTH PARENT
2. Glaucoma			
3. Color Blindness			
4. Blindness (Cause)			
<input type="checkbox"/> Hereditary			
<input type="checkbox"/> Non-hereditary			
Type			
<input type="checkbox"/> Partial			
<input type="checkbox"/> Total			
5. Near-sighted			

## SECTION 5: FAMILY MEDICAL HISTORY CONTINUED

MEDICAL CONDITION (Check all that apply)	S E L F	F A M I L Y	RELATIONSHIP TO BIRTH PARENT
<b>B. EAR &amp; EYE CONDITIONS</b>			
6. Far-sighted			
7. Astigmatism			
8. Deaf (Cause) <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary Type <input type="checkbox"/> Partial <input type="checkbox"/> Total			
9. Other (Specify)			
<b>C. BLOOD, HEART &amp; CIRCULATORY CONDITIONS</b>			
1. Heart Attack			
2. Stroke			
3. Hardening of the Arteries			
4. Blood Clots in the Legs			
5. High Blood Pressure			
6. Anemia			
7. Hemophilia			
8. Sickle Cell Anemia			
9. Other (Specify)			
<b>D. BRAIN &amp; NERVOUS SYSTEM CONDITIONS</b>			
1. Alzheimer's Disease			
2. Multiple Sclerosis			
3. Epilepsy & Other Seizure or Convulsive Conditions			
4. Cerebral Palsy			
5. Parkinson's Disease			
6. Migraine Headaches			
7. Huntington's Disease			
8. Tourette's Syndrome			
9. Other (Specify)			
<b>E. HORMONAL DISORDERS</b>			
1. Diabetes			
2. Thyroid Disorder (Specify) <input type="checkbox"/> Overactive Thyroid <input type="checkbox"/> Under Active Thyroid <input type="checkbox"/> Goiter <input type="checkbox"/> Iodine Deficiency			

MEDICAL CONDITION (Check all that apply)	S E L F	F A M I L Y	RELATIONSHIP TO BIRTH PARENT
3. Pituitary Gland Disorder (Specify) <input type="checkbox"/> Excessive hormone <input type="checkbox"/> Reduced hormone <input type="checkbox"/> Growth hormone deficiency			
4. Other (Specify)			
<b>F. INTELLECTUAL &amp; DEVELOPMENTAL CONDITIONS</b>			
1. Down Syndrome			
2. Mental Retardation (Cause) <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary			
3. Speech/Communications Disorders (Cause) <input type="checkbox"/> Brain damage <input type="checkbox"/> Developmental delay <input type="checkbox"/> Structural abnormality (mouth)			
4. Learning Disorders (Specify) <input type="checkbox"/> Dyslexia (reading) <input type="checkbox"/> Dysgraphia (writing) <input type="checkbox"/> Minimal brain damage			
5. Pervasive Developmental Disorder or Autism			
6. Other (Specify)			
<b>G. MENTAL &amp; BEHAVIORAL CONDITIONS</b>			
1. Schizophrenia			
2. Anxiety Disorder			
3. Major Depressive Disorder			
4. Bipolar Disorder (manic depressive)			
5. Alcoholism			
6. Obsessive Compulsive Disorder			
7. Attention Deficit Disorder (ADD)			
8. Attention Deficit Hyperactivity Disorder (ADJHD)			
9. Drug Abuse			
10. Post Traumatic Stress Disorder			
11. Anorexia Nervosa			
12. Other (Specify)			

MEDICAL CONDITION (Check all that apply)	S E L F	F A M I L Y	RELATIONSHIP TO BIRTH PARENT
<b>H. GASTROINTESTINAL URINARY SYSTEM CONDITIONS</b>			
1. Kidney Disease (Cause) <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary			
2. Liver Dysfunction (Cause) <input type="checkbox"/> Hereditary <input type="checkbox"/> Non-hereditary			
3. Ulcers			
4. Ulcerative Colitis/ Crohn's Disease			
5. Gall Bladder Disorder (Specify) <input type="checkbox"/> Gall Stones <input type="checkbox"/> Infection <input type="checkbox"/> Tumor			
6. Diverticulitis			
7. Other (Specify)			
<b>I. CANCER</b>			
1. Blood (Leukemia)			
2. Colon			
3. Prostate			
4. Uterine			
5. Breast			
6. Lung			
7. Skin			
8. Bone			
9. Brain			
10. Hodgkin's Disease			
11. Pancreas			

MEDICAL CONDITION (Check all that apply)	S E L F	F A M I L Y	RELATIONSHIP TO BIRTH PARENT
12. Liver			
13. Ovarian			
14. Cervical			
15. Stomach			
16. Throat			
17. Other (Specify)			
<b>J. GENETIC CONDITIONS</b>			
1. Muscular Dystrophy			
2. Spina Bifida			
3. Club Foot			
4. Dwarfism			
5. Cystic Fibrosis			
6. Marfan's Syndrome			
7. Tay-Sachs Disease			
8. Hare Lip			
9. Cleft Palate			
10. Other (Specify)			
<b>K. OTHER CONDITIONS</b>			
1. High Cholesterol			
2. Exposure to Chemicals & Toxic Materials (Specify)			
3. Arthritis			
4. Asthma			
5. Obesity			
6. Lupus			
7. Other (Specify)			

To the best of my knowledge, the information contained in this document is a true and factual presentation of my family medical history.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DAYTIME PHONE NUMBER

\_\_\_\_\_  
DATE

*Please attach copy of valid driver's license or have form notarized*

NOTARY  
SEAL