

SURROGATE'S COURT OF THE STATE OF NEW YORK
COUNTY OF _____

In the Matter of the Adoption of
A Child whose First Name is _____

(Docket)(File) No. _____

Child's Medical
History (Agency or
Private-Placement)

1. Age and date of birth of child: _____

2. Has the child had any of the following illnesses or health problems: (Where indicated, specify below or on additional sheet).

- | | |
|--|--|
| <input type="checkbox"/> (AIDS Infection) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> (HIV positive status) ¹ | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Allergy to foods/other substances | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Allergy to medications (prescription or over-the-counter) | <input type="checkbox"/> Mental/Behavioral disorders (specify): |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Parasites in stool |
| <input type="checkbox"/> Circulatory system disorders (specify): | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Sickle Cell Anemia/Trait |
| <input type="checkbox"/> German Measles (Rubella) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Measles (Rubeola) | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Heart problems (specify): | <input type="checkbox"/> Whooping Cough (Pertussis) |
| | <input type="checkbox"/> Other (specify): |
| | <input type="checkbox"/> Operations/Accidents/Fractures (specify): |

3. Immunizations: give dates of the following:

D.P.T/D.T. _____
Polio (oral) _____
Measles _____ Mumps _____ Rubella _____
Hemophilus Influenza B. (H.I.B.) _____
Heptavax/Hepatitis Immune Globulin _____
Influenza (Flu) _____

¹ Delete inapplicable provision.

Pneumonia vaccine _____

Other (specify) _____

Tuberculosis test (most recent/result) _____

4. List Pre-natal History:

___ First trimester bleeding

___ Toxemia (high blood pressure or protein in the urine)

___ Medications (other than vitamins or iron)

___ Diabetes or thyroid problem (specify):

___ Drugs (such as marijuana, heroin, methadone or amphetamines) (specify):

___ Alcohol (occasional)(moderate)(heavy)² (specify):

Birth:

Birth weight _____ length _____

Apgar score: 1 min. _____ 5 mins. _____

Date baby was due _____

Date baby was born _____

Complications of delivery:

___ Premature rupture of membranes

___ Caesarian: routine _____ emergency _____

___ Excessive bleeding: abruption _____ placenta previa _____

Newborn:

___ Resuscitation required

___ Yellow jaundice: lights _____ exchange transfusion _____

___ Infection (specify):

___ Breathing problem (specify):

___ Other (specify):

5. List congenital impairments, including physical defects, if any.

6. State present health or cause of death (give ages), if known, of:

²Delete inapplicable provision.

Birth father:

Birth mother:

Siblings: full:

half:

7. If known, indicate whether birth mother had any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastrointestinal disease,
(e.g., gall bladder, ulcer,
irritable bowel disorder)
(specify): |
| <input type="checkbox"/> Mental or nervous
disorder e.g.,
schizophrenia,
depression, manic
depressive illness
(specify): | <input type="checkbox"/> Breast cancer |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Colon cancer |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Cancer, other (specify): |
| <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Arthritis or rheumatism |
| <input type="checkbox"/> (Aids infection)
(HIV positive status)* | <input type="checkbox"/> Kidney disease
(specify): |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Alcoholism or other substance
abuse (specify): |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Developmental disorder
(e.g., learning disability,
(attention deficit)(specify): |
| <input type="checkbox"/> Eye or ear disorder | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Retardation: mental | |
| <input type="checkbox"/> Physical disability (specify): | |
| <input type="checkbox"/> Circulatory or blood
disorders (specify): | |
| <input type="checkbox"/> Obesity | |

8. If known, indicate whether birth father had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gastrointestinal disease
(e.g., gall bladder, ulcer,
irritable bowel disorder)
(specify): |
| <input type="checkbox"/> Mental or nervous
schizophrenia,
depression, manic
depressive illness
(specify): | <input type="checkbox"/> Colon cancer |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Cancer, other
(specify): |
| <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Sickle cell anemia | |

___ (AIDS infection)
(HIV positive status)*

___ Arthritis or rheumatism
___ Kidney disease
(specify):

*Delete inapplicable provision.

___ High blood pressure
___ Bleeding tendency
___ Eye or ear disorders
___ Retardation: mental
___ Physical disability
(specify)
___ Circulatory or blood
disorders (specify):
___ Obesity

___ Alcoholism or other substance
abuse (specify):

___ Developmental disorder
(e.g., learning disability,
attention deficit disorder)
(specify):
___ Other (specify):

Indicate source for information about child's medical history and the source(s) for information about medical history of birth father and birth mother and whether from direct or indirect source:

Completed by (state official title, if any): _____

Petitioner

Print or type name

Signature of Attorney, if any

Attorney's Name (Print or Type)

Attorney's Address and Telephone Number