STATE OF VERMONT

SUPERIOR COURT PROBATE DIVISION

Unit Docket No.

In re Adoption of :

INFORMATION ABOUT BIRTH FAMILY

Each Birth Parent should complete a separate form.

Today's Date: ______________________________

Name of person completing form: ____

If not parent, relationship to parent: ____

Child's Full Name: ____

Date of Birth: _______________________________ Time of Birth: ______________________________

Place of Birth *(town, state, country)*: ____

BIRTH PARENT BACKGROUND

Parent's Full Name *(first, middle, last)*: ____

Maiden or previous name(s), if applicable: ____

Date of Birth: ___________________ Place of Birth: ____

Social Security Number: _______________ Driver's License Number: _______________ State: ______

Race: _______________________________ Ethnic Background: ___________________________________

If you attend religious services, what kind? ____

Physical Address

____

____

____

Mailing Address

____

____

____

Please provide the name and address of a person who is likely to know where you are if you move:

____

____

____

PHYSICAL DESCRIPTION

Height: ______________ Weight: ______________ Complexion: _______________

Hair Color: ___________ Eye Color: ____________ General Build: _____________

PERSONAL BACKGROUND

Where did you grow up? ____

What is the highest grade you have completed? __________ How did you do in school? ___________

What were your favorite subjects? ____

If you had learning problems in school, what were they? _______________________________________

____

If you have had other training, what kind? ____

What kind of jobs have you had? ____

Present occupation: ____

Briefly describe your personality:

____

____

____

What are your interests and talents? *(examples of talents: artistic, mechanical, athletic, like science, musical, etc.)*

____

____

____

Have you been in the military? ☐ Yes ☐ No

If Yes, what branch? ______________________

What was your rank and serial number?____

What are your plans for the future?

____

____

____

____

____

BIRTH PARENT'S FAMILY

Your **mother's** name *(first, middle, maiden)*: ____

Height: ______________ Weight: ______________ Age: ___________ Race: __________

Hair Color: ___________ Eye Color: ____________ General Build: _________________________

General Health: ____

Level of Education: _____________________________ Occupation: ____________________________

Is she aware of the birth of this child? ☐ Yes ☐ No

If deceased, age and cause of death: ____

BIRTH PARENT'S FAMILY *(continued)*

Your **father's** name*)*: ____

Height: ______________ Weight: ______________ Age: ____________ Race: __________

Hair Color: ___________ Eye Color: ____________ General Build: _________________________

General Health: ____

Level of Education: _____________________________ Occupation: ___________________________

Is he aware of the birth of this child? ☐ Yes ☐ No

If deceased, age and cause of death: ____

BROTHERS AND SISTERS

Full Name	Male / Female	Date of Birth	Last Grade Completed	Occupation
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			

MARRIAGES

Name of Spouse	Year Married	Year Divorced

BROTHERS AND SISTERS OF YOUR CHILD *(Include brothers and sisters living at home or elsewhere including children who were adopted, step-brothers and sisters and any children who may have lived in the child's home for an extended period of time.)*

Full Name	Male / Female	Date of Birth	Relationship to Child	Who is Caring for this Child?
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			
	☐ M / ☐ F			

Does your child have a relationship with these brothers and sisters? Please describe.

____
____
____
____
____
____

PREGNANCY *(for birthmothers only)*

In what month did you begin pre-natal care? ____________________

Did you drink alcohol during this pregnancy? When during your pregnancy? How much at one time and how often?

____
____

What prescription drugs, over-the-counter medications or street drugs did you take during your pregnancy? What kind, how often, and when during the pregnancy?

____
____

Did you smoke? If so, how much? ____

Did you have any special problems during pregnancy? (for example: high blood pressure, diabetes, excessive bleeding, kidney or bladder infections, German or Three Day Measles, operations, convulsions, x-rays, sexually transmitted diseases or others):____________________

At what age did you get your period? ____________________________

YOUR CHILD'S HISTORY

Where was your child born? ____

Was this child born earlier or later than expected? ☐ Earlier ☐ Later

If so, how much earlier or later? ________________ How long was your labor?_______________

If drugs were used during your labor, what kind? ____

Were forceps used? ☐ Yes ☐ No

If you had a Caesarian Section (C-section), why? ____

If your child had any problems during the labor or soon after birth, please describe:

____
____
____

What was your child's birth weight? _______________ Birth length: ______________

Did your child have special problems at birth? Please describe:

____
____

What is the name and address of your child's doctor?

____

FOR CHILDREN WHO ARE NOT NEWBORNS

Who has your child's immunization records? ____

What illnesses has your child had?

☐ Chicken Pox	☐ Bladder or Kidney Infection	☐ Mumps
☐ Ear infections	☐ Whooping Cough	☐ Hepatitis
☐ Frequent nausea or vomiting	☐ Meningitis Red	☐ Measles
☐ Frequent diarrhea or constipation	☐ Sore throat	☐ Allergies
☐ Seizures or convulsions	☐ Headaches	☐ Dizziness
☐ Rash/Skin problems	☐ Asthma	☐ Hay Fever
☐ Broken bones	☐ Fainting	☐ Dental cavities
☐ Pneumonia	☐ Frequent swollen glands	☐ Rheumatic Fever
☐ Trouble urinating	☐ Frequent bruises or bleeding	☐ Hospitalizations
☐ Major operations, illnesses or accidents		☐ Anemia

If you checked any of the above, please describe:

____

____

____

____

____

If your child has special educational needs, what are they?

____

____

If your child has been formally evaluated for any special problems, what was the evaluation for?

☐ Medical problem ☐ Dental or orthodontic

☐ Learning/school problems ☐ Emotional disturbance or mental illness

☐ Other: what kind? ____

If so, you may be asked to sign releases so that copies of the evaluations can be obtained.

Has your child been abused or neglected in the past?

☐ Physical abuse ☐ Emotional or verbal abuse

☐ Sexual abuse ☐ Neglect

If so, you may be asked to provide more information about the abuse or neglect.

If your child has ever lived with relatives, foster parents or other place away from home, please describe:

____

____

____

____

____

FAMILY MEDICAL HISTORY

Instructions:

If you have any of the problems listed below, or have had any problem in the past, please place a check in the box. If another family member has had the problem, place a check in the box and then list that person's relationship to you (examples: aunt, brother, grandmother). If you have more information about the particular problem, please provide it at the end of this section.

Acne or pimples ☐ Myself ☐ Other family member: ________________

HIV infection or AIDS ☐ Myself ☐ Other family member: ________________

Alcohol Abuse ☐ Myself ☐ Other family member: ________________

Allergy to Food ☐ Myself ☐ Other family member: ________________
What kind? ____

Allergy to Other Things ☐ Myself ☐ Other family member: ________________
What kind? ____

Alzheimer's ☐ Myself ☐ Other family member: ________________

Anemia ☐ Myself ☐ Other family member: ________________

Anencephaly ☐ Myself ☐ Other family member: ________________
(born with no brain)

Arthritis ☐ Myself ☐ Other family member: ________________
Where? ____

Bedwetting ☐ Myself ☐ Other family member: ________________

Bipolar illness ☐ Myself ☐ Other family member: ________________
(manic depression)

Birth defects ☐ Myself ☐ Other family member: ________________
What kind? ____

Blindness or very poor sight ☐ Myself ☐ Other family member: ________________

Braces on teeth ☐ Myself ☐ Other family member: ________________

Breast cancer ☐ Myself ☐ Other family member: ________________

Bronchitis ☐ Myself ☐ Other family member: ________________

Hodgkin's Disease ☐ Myself ☐ Other family member: ________________

Cancer ☐ Myself ☐ Other family member: ________________
What kind? ____

Chlamydia ☐ Myself ☐ Other family member: ________________

Cleft lip or palate ☐ Myself ☐ Other family member: ________________

Club foot ☐ Myself ☐ Other family member: ________________

Condition	Myself	Other family member
Colitis	☐ Myself	☐ Other family member: ________________
Color blindness	☐ Myself	☐ Other family member: ________________
Cystic Fibrosis	☐ Myself	☐ Other family member: ________________
Dental Problems	☐ Myself	☐ Other family member: ________________
What kind? ________________		
Deafness/hearing problems	☐ Myself	☐ Other family member: ________________
Diabetes in childhood	☐ Myself	☐ Other family member: ________________
Diabetes adulthood onset	☐ Myself	☐ Other family member: ________________
Down's Syndrome	☐ Myself	☐ Other family member: ________________
Drug Abuse	☐ Myself	☐ Other family member: ________________
Dwarfism/very short height	☐ Myself	☐ Other family member: ________________
Ear infections	☐ Myself	☐ Other family member: ________________
Eczema	☐ Myself	☐ Other family member: ________________
Emphysema	☐ Myself	☐ Other family member: ________________
Epilepsy or seizures	☐ Myself	☐ Other family member: ________________
Eye problems	☐ Myself	☐ Other family member: ________________
Genital Warts	☐ Myself	☐ Other family member: ________________
Very tall height	☐ Myself	☐ Other family member: ________________
Glasses	☐ Myself	☐ Other family member: ________________
What kind? ________________		
Glaucoma	☐ Myself	☐ Other family member: ________________
Gynecological Problems *(female)*	☐ Myself	☐ Other family member: ________________
What kind? ________________		
Gonorrhea	☐ Myself	☐ Other family member: ________________
Headaches or migraines	☐ Myself	☐ Other family member: ________________
Heart attack/heart problems	☐ Myself	☐ Other family member: ________________
Hemochromatosis	☐ Myself	☐ Other family member: ________________
Hemophilia or bleeding	☐ Myself	☐ Other family member: ________________
Hepatitis	☐ Myself	☐ Other family member: ________________
Herpes	☐ Myself	☐ Other family member: ________________

Hives ☐ Myself ☐ Other family member: ________________

High blood pressure ☐ Myself ☐ Other family member: ________________

Huntington's Chorea ☐ Myself ☐ Other family member: ________________

Infertility/difficulty getting pregnant
☐ Myself ☐ Other family member: ________________

Jaundice or yellow skin ☐ Myself ☐ Other family member: ________________

Kidney disease ☐ Myself ☐ Other family member: ________________

Learning problems or disabilities
☐ Myself ☐ Other family member: ________________

Left handed ☐ Myself ☐ Other family member: ________________

Liver disease ☐ Myself ☐ Other family member: ________________

Lung problem ☐ Myself ☐ Other family member: ________________

Lupus ☐ Myself ☐ Other family member: ________________

Mental illness ☐ Myself ☐ Other family member: ________________
What kind? ____

Miscarriages ☐ Myself ☐ Other family member: ________________

Muscular Dystrophy ☐ Myself ☐ Other family member: ________________

Obesity/significant overweight
☐ Myself ☐ Other family member: ________________

Osteoporosis ☐ Myself ☐ Other family member: ________________

Paralysis ☐ Myself ☐ Other family member: ________________

Phenylketonuria (PKU) ☐ Myself ☐ Other family member: ________________

Rectal or intestinal polyps ☐ Myself ☐ Other family member: ________________

Rheumatic fever ☐ Myself ☐ Other family member: ________________

Schizophrenia ☐ Myself ☐ Other family member: ________________

Serious depression ☐ Myself ☐ Other family member: ________________

Sickle cell anemia ☐ Myself ☐ Other family member: ________________

Skin disease ☐ Myself ☐ Other family member: ________________

Spina bifida ☐ Myself ☐ Other family member: ________________

Speech problems ☐ Myself ☐ Other family member: ________________
What kind? ____

Still births ☐ Myself ☐ Other family member: _______________

Stomach problems ☐ Myself ☐ Other family member: _______________
What kind? ____

Strokes ☐ Myself ☐ Other family member: _______________

Suicide/suicide attempt ☐ Myself ☐ Other family member: _______________

Surgery ☐ Myself ☐ Other family member: _______________
What kind? ____

Syphilis ☐ Myself ☐ Other family member: _______________

Sachs Disease ☐ Myself ☐ Other family member: _______________

Thalassemia ☐ Myself ☐ Other family member: _______________

Thyroid problems ☐ Myself ☐ Other family member: _______________

Twins or multiple births ☐ Myself ☐ Other family member: _______________

Ulcers ☐ Myself ☐ Other family member: _______________

Varicose veins ☐ Myself ☐ Other family member: _______________

Wilson's Disease ☐ Myself ☐ Other family member: _______________

Other: ____

Have you ever had a formal evaluation for medical, mental health or educational reasons?
☐ Yes ☐ No
Please explain:
____
____
____

ADOPTION PLANS FOR YOUR CHILD

What led to your decision to plan adoption for your child?
____
____
____
____
____
____
____