ARIZONA DEPARTMENT OF HEALTH SERVICES

Bureau of Vital Records
P.O. Box 6018
Phoenix, Arizona 85005
602-364-1300

# Birth Parent Medical History Form

**Instructions:** Please complete this form to the best of your ability. For any field(s) you do not know or would not like to share please indicate "unknown" in the given field. This is a fillable form which can be completed electronically before printing. If you are completing this form by hand, please print clearly.

All information provided is confidential communication from the birth parent. This information will not be used for any statistical purpose or be disclosed to anyone other than the adoptee.

**Mail the completed form to:** The Bureau of Vital Records, P.O. Box 6018, Phoenix, Arizona 85005.

| **Child's Information** | |
|---|---|
| Name on Original Birth Record | |
| Date of Birth | |
| Sex | ☐ Male ☐ Female |
| Hospital Name (or street number and name) | |
| City/Town of Birth | |
| County of Birth | |
| Mother's Name Prior to First Marriage | |

| **Parent's Information** | | | |
|---|---|---|---|
| **Today's Date** | | **I am the:** ☐ Birth Mother ☐ Birth Father | |
| **Birth Mother** | | **Birth Father** | |
| Age at Child's Birth | | Age at Child's Birth | |
| Height | | Height | |
| Weight | | Weight | |
| Eye Color | | Eye Color | |
| Highest Level of Education | | Highest Level of Education | |
| Hair Color | | Hair Color | |
| Race | | Race | |
| Ethnic Background | | Ethnic Background | |
| Blood Type | | Blood Type | |

Child's Name: Today's Date: I am the: ☐ Birth Mother ☐ Birth Father

**Please provide the medical history for yourself and your blood relatives (i.e. parents, siblings, grandparents, etc). Please check all that apply and specify type where indicated.**

| MEDICAL CONDITION | SELF | FAMILY | MEDICAL CONDITION | SELF | FAMILY |
|---|---|---|---|---|---|
| Respiratory (lungs) | | | Endocrine Disorders | | |
| Allergies (including food/drug) | | | Diabetes (Adult or Juvenile) | | |
| Asthma | | | Thyroid (Hyper/Hypo) | | |
| COPD | | | Muscular/Skeletal Disorders | | |
| Emphysema | | | Club Foot | | |
| Cystic Fibrosis | | | Scoliosis | | |
| Gastrointestinal (stomach and intestines) | | | Osteoarthritis | | |
| Ulcers | | | Rheumatoid Arthritis | | |
| Inflammatory Bowel Disease | | | Muscular Dystrophy | | |
| Cleft Lip or Palate | | | Lupus | | |
| Diverticulosis | | | Immune/Hematological Disorders | | |
| Crohn's Disease | | | Hemophilia | | |
| Irritable Bowel Syndrome | | | Leukemia (Acute or Chronic) | | |
| Cardiovascular (heart and blood vessels | | | Factor V Leiden | | |
| High Blood Pressure | | | Sickle Cell Anemia | | |
| Heart Attack | | | Eye and Ear Disorders | | |
| Stroke | | | Blindness | | |
| Heart Disease | | | Glaucoma | | |
| Heart Rhythm Abnormality | | | Deafness | | |
| Congenital Heart Defect | | | Malignant Conditions | | |
| Renal Disorders (kidneys) | | | Cancer – Specify Type: | | |
| Chronic Kidney Disease | | | Reproductive Issues | | |
| Kidney Failure | | | Fertility Issues | | |
| Liver Disorders | | | History of Miscarriage | | |
| Hepatitis – Specify Type: | | | Endometriosis | | |
| Cirrhosis | | | Developmental Disorders | | |
| Nervous System (brain and nerves) Disorders | | | Learning Disability | | |
| Epilepsy | | | Autism Spectrum | | |
| Hydrocephalus | | | Physical Disability | | |
| Multiple Sclerosis | | | Mental and Behavioral Disorders | | |
| Huntington's Disease | | | Anorexia | | |
| Parkinson's Disease | | | Substance Abuse (alcohol, illegal drugs, prescription drugs, cigarettes) | | |
| Alzheimer's Disease | | | | | |
| Spina Bifida | | | Bulimia | | |
| Cerebral Palsy | | | Bipolar Disorder | | |
| Amyotrophic Lateral Sclerosis | | | Schizophrenia | | |
| Tay-Sachs Disease | | | Chronic Depression | | |

You may submit an updated form by sending a new form to: ADHS, P.O. Box 6018, Phoenix, AZ 85005