

New Hampshire Department of State
 Division of Vital Records Administration
 9 Ratification Way
 Concord, New Hampshire 03301-2455

NH Birth Parent Updated Medical History

Name of Child on Birth Record: _____
 Date of Birth: _____ Sex: Male Female Hospital: _____
 County: _____ City: _____
 Mother's Name (as shown on birth certificate): _____
 Adoption agency involved with adoption (if known): _____
 Today's Date: _____ Parent completing this form is: Birth Mother Birth Father

If information is unknown (unk) or not available (N/A) please indicate.

For each of the medical conditions described below, please check the appropriate column indicating whether you or any blood relative, i.e. your mother, father, sisters, brothers, grandparents, aunts, uncles or any other children, have the condition listed. Complete the "Comments" section, as needed using a separate sheet of paper if additional space is required.

MEDICAL CONDITION	NO	NOT KNOWN	YES (SELF)	YES (RELATIVE)	COMMENTS
1. Club Foot					
2. Cleft lip or cleft palate					
3. Congenital heart defect					
4. Any other malformations, Scoliosis					
5. Muscular Dystrophy					Part of body involved? Age at onset?
6. Multiple Sclerosis					
7. Cerebral Palsy					
8. Other paralysis or crippling disorder					
9. Seizures, convulsions or epilepsy					Age at onset? What Treatment? Frequency?
10. Blindness, glaucoma or other visual problems					Age at onset? Cause? Special Education?
11. Deafness or other ear problems					

12. Speech problem					Age at onset? Cause? Special Education?
13. Learning disability					
14. Mental or physical retardation:					Any diagnosis or cause? Hospitalized?

MEDICAL CONDITION	NO	NOT KNOWN	YES (SELF)	YES (RELATIVE)	COMMENTS
15. Diabetes					Age at onset? Treatment?
16. Thyroid disorder					
17. Other hormonal disorder					
18. Bronchitis					
19. Emphysema					
20. Congestive Heart Failure					
21. Artherosclerosis					
22. Eczema or other skin conditions					Any cause known? Treatment? Medication?
23. Asthma					
24. Hay fever or other allergy					
25. Schizophrenia					Age at onset? Treatment? Hospitalization?
26. Depressive, Bipolar					
27. Other mental or emotional illness, Anorexia, Bulimia					
28. Hypertension (high blood pressure)					
29. Stroke					

30. Heart attack (Coronary)					
31. Other cardiovascular problems					
32. Cancer					What kind? Age at onset? What part of body?
33. Tumors					
34. Cystic Fibrosis					
35. Huntington's Disease					
36. Tuberculosis					
37. Kidney disease					Age of onset? Treatment?
38. Alcoholism or drug addiction					Kind and amount and when taken.

MEDICAL CONDITION	NO	NOT KNOWN	YES (SELF)	YES (RELATIVE)	COMMENTS
39. Any other conditions you or others in your family might have					

DRUGS AND ALCOHOL USE DURING PREGNANCY	NO	NOT KNOWN	YES (SELF)	YES (RELATIVE)	COMMENTS
Prescription drugs taken during pregnancy					Kind taken, when, amount and frequency
Non-prescription drugs taken during pregnancy					Kind taken, when, amount and frequency
Did you use alcohol during pregnancy?					Amount and frequency
Amphetamines used during pregnancy					Kind taken, when, amount and frequency
Barbiturates used during pregnancy					Kind taken, when, amount and frequency

OTHER INFORMATION ON BIRTH PARENTS

Information given should be at the time of the child's birth. Do not include any identifying information.

Height	Weight	Body build
Eye color	Hair color	Skin color
Age	Race	Nationality (citizenship)
Ethnic background	Religion	Number of school years completed
Mother's blood type	RH factor	Baby's blood type

Give age at death and cause of death of child's grandparent, aunt uncle and siblings:

INFORMATION ON THIS PREGNANCY

Is the baby's father aware of this pregnancy?	<input type="radio"/> Yes	<input type="radio"/> No	
Month prenatal care began for this pregnancy	_____		
Complications, if any	_____		
Exposure during pregnancy:	<input type="radio"/> X-Ray	<input type="radio"/> Electrocardiogram	<input type="radio"/> Radiation

CHILD'S BIRTH HISTORY

Any Comments: _____
