

FORM 126. INFORMATION ABOUT BIRTH FAMILY

STATE OF VERMONT
DISTRICT OF _____, SS

PROBATE COURT
Docket No. _____

IN RE THE ADOPTION OF _____,

INFORMATION ABOUT BIRTH FAMILY

(Each birth parent should complete a separate form. Please use black ink and print clearly.)

Name of person completing form: _____

Today's Date: _____

If not parent, relationship to parent: _____

Child's Full Name: _____

Date of Birth: _____ Time of Birth: _____

Place of Birth (town, state, country): _____

BIRTHPARENT 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?

Present 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 so, what branch? _____

What was your rank and serial number? _____

What are your plans for the future? _____

BIRTHPARENT'S FAMILY

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

Age: _____ Height: _____ Weight: _____

Hair color: _____ Eye Color: _____ Race: _____

General Build: _____

General Health: _____

Level of education: _____ Occupation: _____

Is she aware of the birth of this child? _____

If deceased, age and cause of death: _____

Your father's name (first, middle, last): _____

Age: _____ Height: _____ Weight: _____

Hair color: _____ Eye Color: _____ Race: _____

General Build: _____

General Health: _____

Level of education: _____ Occupation: _____

Is he aware of the birth of this child? _____

If deceased, age and cause of death: _____

BROTHERS AND SISTERS

Full Name	M/F	Date of Birth	Last Grade Completed	Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

MARRIAGES

Name of Spouse	Year of Marriage	Year of Divorce
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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.)

Name	M/F	Date of Birth	Relationship to Child	Who is Caring for this Child?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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 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? _____ Early _____ Later

If so, how much early or late? _____

How long was your labor? _____

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

Were forceps used? _____

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: _____

Please list 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?

- | | |
|---|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Seizures or convulsions |
| <input type="checkbox"/> Bladder or kidney infections | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Rash/skin problems |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Asthma, hay fever |
| <input type="checkbox"/> Frequent nausea or vomiting | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Frequent diarrhea or constipation | <input type="checkbox"/> Dental cavities |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Red measles | <input type="checkbox"/> Frequent swollen glands |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Trouble urinating |
| <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Major operations, illnesses or accidents | <input type="checkbox"/> Frequent bruises or bleeding |

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?

- | | |
|--|---|
| <input type="checkbox"/> Medical problem | <input type="checkbox"/> Dental or orthodontic |
| <input type="checkbox"/> Emotion disturbance or mental illness | <input type="checkbox"/> Learning/school problems |
| <input type="checkbox"/> 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?

- | | |
|---|--|
| <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Emotional or Verbal Abuse |
| <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> 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 checkmark on the line. 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 _____

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? _____

Stillbirths	Myself _____	Other family member _____
Stomach problems	Myself _____	Other family member _____

What kind? _____

Strokes	Myself _____	Other family member _____
Suicide/suicide attempt	Myself _____	Other family member _____

