SECTION II – NON IDENTIFYING INFORMATION ABOUT BIRTHMOTHER

This information will be given to the adopting parents and will be available to your child. Please answer all questions as completely as possible. (Initial) L.S

PART I – CHARACTERISTICS OF BIRHTMOTHER AT TIME OF ADOPTEE'S BIRTH

A. GENERAL INFORMATION AND PHYSICAL DESCRIPTION:

HEIGHT	USUAL WEIGHT	EYE COLOR	SKIN COLOR	NATURAL HAIR COLOR	NATURAL HAIR TEXTURE (CHECK ALL THAT APPLY)
5'4	160	brown	brown	black	☐ FINE ☐ MEDIUM ☐ COARSE ☒ STRAIGHT ☐ WAVY ☐ CURLY ☐ BALDING

BIRTHDATE (YEAR ONLY)	BIRTHPLACE (STATE ONLY)	BLOOD TYPE	RH FACTOR	BODY TYPE	ARE YOU RIGHT HANDED ☐
2000	Nevada			☐ SMALL BONED ☒ MEDIUM BONED ☐ LARGE BONED	LEFT HANDED ☒

Race/Ethnic Group
☐ White ☒ Hispanic ☐ Filipino ☐ Black ☐ Asian or Pacific Islander
☐ American Indian or Alaskan Native ☐ Other (Specify) _____

If American Indian or Alaskan Native, please specify name of tribe and degree of Indian blood (if known)

Mexican
SPECIFIC NATIONALITY DESCENT (EXAMPLE: IRISH, FRENCH, GERMAN, CANTONESE, MEXICAN, NIGERIAN)

B. EDUCATION:

LAST GRADE COMPLETED	PRESENTLY IN SCHOOL	USUAL GRADES IN SCHOOL	OTHER TRAINING
	☐ YES ☒ NO	Average	

EXTRA CURRICULAR ACTIVITIES

Medical Field
SUBJECTS INTERESTED IN

C. OCCUPATION:

PRESENT OCCUPATION	HOW LONG?	USUAL OCCUPATION
Amazon	1 year	

WHAT ARE YOUR OCCUPATIONAL GOALS? (EXAMPLE: TO BE A TEACHER, WELDER, SALES CLERK)

MA (Medical Assistant)

D. PERSONALITY:

DESCRIBE YOUR PERSONALITY IN TERMS OF YOUR USUAL BEHAVIOR, ATTITUDES, MOODS, ACITIVITIES YOU USUALLY PARTICIPATE IN, TYPES OF PEOPLE YOU ENJOY BEING WITH, ETC.

I'm nice, understanding, good listener, sometimes moody, Shy. I like to be with my boyfriend and his family. I also like to be around nice people.

DESCRIBE TALENTS, HOBBIES AND GOALS IN LIFE.

I like to clean and cook not the best at drawing but I like to draw sometimes and also read sometimes. In the future I'd like to be in the medical field.

DESCRIBE HOW YOU WERE AS A CHILD

As a child I was shy and quite at school, if I was around friends and family I'd be less shy. I'd like to be around family a lot.

E. ADOPTION QUESTIONS:

Religion:

What Religion do you practice: Catholic

ARE YOU WILLING TO HAVE YOUR CHILD REARED IN THE RELIGIOUS FAITH OF THE ADOPTING PARENTS, IF DIFFERENT FROM YOUR OWN? ☐ YES ☒ NO

IF NO, WHAT RELIGIOUS FAITH DO YOU WISH YOUR CHILD TO BE REARED? Catholic

WHY DID YOU PLACE THIS CHILD FOR ADOPTION? (PLEASE RESPOND AS THOROUGHLY AS YOU CAN. THIS IS THE QUESTION ADULT ADOPTEES MOST OFTEN ASK ADOPTION AGENCIES.)

I'm placing my child up for adoption because as a young parent I've seen other young parent struggle and I'd like my baby to be placed with a couple that's ready and expecting a baby. I also know that when two people aren't ready which is my case they have to work twice as hard to get by and we'll bearly have time for the baby and since I've felt that as a kid I really want different for my baby. I'd want him to be with a stable and really loving family that's ready and expecting.

IF YOUR CHILD WAS NOT PLACED FOR ADOPTION AT BIRTH, GIVE INFORMATION ON THE CHILD'S CARE, HEALTH AND DEVELOOPMENT BEFORE PLACEMENT.

HOW DO YOU FEEL ABOUT BEING CONTACTED BY THE ADOPTEE WHEN HE OR SHE REACHES ADULTHOOD?

I would love for the kid to contact me as an adult as long as everyone in his life would be okay with it. I would love to know if he's doing okay. I wouldn't mind at all and I'm hoping that when he's an adult he contacts me and the father.

F. BIRTHMOTHER'S MENSTRUAL HISTORY AND PREGNANCY HISTORY OF CHILD:

1. MENSTRUAL HISTORY

HOW OLD WERE YOU WHEN YOU BEGAN TO MENSTRUATE?	WHAT IS THE USUAL LENGTH OF YOUR PERIOD?	ARE YOU REGULAR?	NO. OF DAYS IN CYCLE
14 years old	3-4 days	☐ YES ☒ NO	

DO YOU HAVE PROBLEMS WITH YOUR PERIODS? ☒ YES ☐ NO ☐ IF YES, EXPLAIN

WERE YOU A "DES" BABY? ☐ YES ☐ NO ☒ UNKNOWN

2. THIS PREGNANCY

NAME AND ADDRESS OF OBSTETRICIAN WHO PROVIDED YOU WITH PRENATAL CARE:

NAME OF OBSTETRICIAN: | ADDRESS: 1701 W. Charleston Blvd Suite 130 | STREET | CITY, Las Vegas, | STATE NV, | ZIP CODE 89102

WHEN DID PRENATAL CARE BEGIN?	WHAT WAS YOUR AGE WHEN YOU BECAME PREGNANT?	NUMBER OF WEEKS THIS PREGNANCY?	TYPE OF BIRTH
8/20/21	20	29 weeks 1 day	☐ SINGLE ☐ MULTIPLE IF MULTIPLE, HOW MANY?

COMPLICATIONS DURING THIS PREGNANCY? ☐ YES ☒ NO ☐ IF YES, EXPLAIN

HAVE YOU GIVEN BIRTH TO ANY OTHER CHILDREN? ☐ YES ☒ NO ☐ IF YES HOW MANY

3. CONDITIONS DURING THIS PREGNANCY

GERMAN MEASLES	☐ YES	☐ NO	☐ HERPES	☐ GONORRHEA	☐ SYPHILIS	VIRUS (E.G., FLU)	☐ YES	☐ NO
INFECTIONS	☐ YES	☐ NO	☐ CHLAMYDIA	☐ GENITAL WARTS		ACCIDENTS	☐ YES	☐ NO

IF YES TO ANY OF THE ABOVE, SPECIFY TYPE OF CONDITION(S), DATE(S) AND TYPE OF TREATMENT

4. DRUGS TAKEN DURING, AND WITHIN ONE YEAR PRIOR, TO THIS JPREGNANCY:

	TAKEN DURING THIS PREGNANCY (Check √ under appropriate column)		TAKEN WITHIN ONE YEAR PRIOR TO PREGNANCY		WHEN?	HOW OFTEN?	AMOUNT?
a. Prescription Drugs: [Give name(s)]	YES	NO	YES	NO			
1.							
2.							
3.							
4.							
b. Nonprescription Drugs, Including aspirin, nose drops, etc.							
1.							
2.							
3.							
4.							
c. Alcohol and other substances:							
1. Alcohol (wine, beer, etc)	X		X		July 19, 21	Once	1 can
2. Amphetamines (uppers)		√		√			
3. Barbiturates (downers)		√		√			
4. Tobacco		√		√			
5. Cocaine		√		√			
6. Crack		√		√			
7. Heroin		√		√			
8. LSD		√		√			
9. PCP		√		√			
10. Marijuana	X		X	√		often	not sure
11. Other (specify)		√		√			

Have you ever been an IV drug user? ☐ YES ☐ NO

G. PERSONAL HEALTH HISTORY

DESCRIBE YOUR GENERAL HEALTH

WHAT CHILDHOOD DISEASES HAVE YOU HAD?

MEASLES ☐ RUBELLA (3 DAY) ☐ RUBELLA (2 WEEK) ☐ MUMPS ☐ CHICKEN POX ☐ WHOOPING COUGH ☐ HAYFEVER ☐ ROSEOLA ☐ ASTHMA ☐ EAR INFECTIONS ☐ ENCEPHALITIS ☐ MENINGITIS ☐ EAR RHEUMATIC FEVER ☐ HEART MURMUR ☐ SCARLET FEVER ☐ RHEUMATIC FEVER ☐ URINARY/BLADDER INFECTIONS ☐ OTHER (Specify)

ANY MAJOR SURGERY? ☐ YES ☒ NO IF YES, FOR WHAT CONDITIONS/and when?

ARE YOU A: ☐ TWIN ☐ TRIPLET ☐ OTHER MULTIPLE BIIRTH ARE YOU AN ☐ IDENTICAL OR ☐ FRATERNAL TWIN

H. FAMILY HISTORY

WERE YOU OR ANY MEMBER OF YOUR IMMEDIATE FAMILY ADOPTED?

☐ YES ☒ NO IF YES, PLEASE TELL WHO

	YOUR BIOLOGICAL FATHER	YOUR BIOLOGICAL MOTHER
Current age	59 yeurs old	56 years old
If deceased, age at death		
Cause of death		
Height & Weight	HEIGHT 5'0 WEIGHT 170	HEIGHT 5'0 WEIGHT 180
Hair color and texture	black / straight	black / straight
Eye color	brown	brown
Skin color	brown	brown
Left or right handed	right hand	right hand
Outstanding features		
Education Completed	4th grade	3rd grade
Occupation		
Race/Ethnic Group	☐ WHITE ☒ HISPANIC ☐ BLACK ☐ FILIPINO ☐ ASIAN OR PACIFIC ISLANDER ☐ OTHER (SPECIFY ☐ AMERICAN INDIAN OR ALASKAN NATIVE	☐ WHITE ☒ HISPANIC ☐ BLACK ☐ FILIPINO ☐ ASIAN PACIFIC ISLANDER ☐ OTHER (SPECIFY) ☐ AMERICAN INDIAN OR ALASHAN NATIVE
Nationality	Mexican	Mexican
Religion	Catholic	Catholic
Was this parent aware of your pregnancy?	☒ YES ☐ NO	☒ YES ☐ NO
How many brothers or sisters did she/he have?	7	7
If any of your aunts or uncles have died, give age at death and cause of death.		

	YOUR FATHER'S PARENTS		YOUR MOTHER'S PARENTS	
	FATHER	MOTHER	FATHER	MOTHER
Age				
If deceased, age at death and cause of death				
Describe physical appearance				
Height & Weight	HEIGHT WEIGHT		HEIGHT WEIGHT	
Outstanding Features				
Education completed				
Current of former occupation				
Was he/she aware of your pregnancy?	☐ YES ☐ NO		☐ YES ☐ NO	

H. FAMILY HISTORY: (continued)

YOUR BROTHERS AND SISTERS

(If you have more than 4 siblings, please use additional paper)

	1	2	3	4
Sex (Male or Female)	Male	Female		
Age	11 years old	4 years old		
If deceased, age at death and cause				
Full or half sibling to you?	☒ FULL ☐ HALF	☒ FULL ☐ HALF	☐ FULL ☐ HALF	☐ FULL ☐ HALF
Height & Weight	HEIGHT / WEIGHT	HEIGHT / WEIGHT	HEIGHT / WEIGHT	HEIGHT / WEIGHT
Hair color and texture	straight / Black	straight / black short		
Eye color	dark brown	dark brown		
Skin color	brown	brown		
Hobbies and talents	drawing / painting	drawing / painting		
Last grade completed	6th grade	8th grade		
Presently in school?	☒ YES ☐ NO	☒ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Occupation				
Aware of Pregnancy?	☐ YES ☒ NO	☐ YES ☒ NO	☐ YES ☐ NO	☐ YES ☐ NO
Marital Status	Good	Good		
Number of children they have	0	0		
Health of their children				

YOUR OTHER CHILDREN

(If you have more than 4 children, please use additional paper)

	Child #1	Child #2	Child #3	Child #4
Indicate if son or daughter				
Birthday (mo/day/yr) or age				
Full or half sibling to you?	☐ FULL ☐ HALF	☐ FULL ☐ HALF	☐ FULL ☐ HALF	☐ FULL ☐ HALF
If deceased, age at death				
Cause of death				
Height & Weight	HEIGHT / WEIGHT	HEIGHT / WEIGHT	HEIGHT / WEIGHT	HEIGHT / WEIGHT
Hair color and texture				
Eye color				
Skin color				
Left or right handed				
Grade completed				
Does this child live with you	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Hobbies and talents				
General health				
Major surgery				
Health problems				
Was this child aware of the pregnancy?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

I. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES

Indicate by checking appropriate box if YOU or any RELATIVES (i.e., your parents, sisters, brothers, aunts, uncles, grandparents, other children born to you, etc.) have had or now have the medical conditions listed below. Indicate person's relationship to you. Please complete Comments Section. If a medical condition resulted in death of a family member, indicate this and the person's approximate age at time of death in Comments Sections.

MEDICAL CONDITION	NO	Not Known	YES Self	YES – RELATIVE *(Specify relationship)*	COMMENTS
A CONGENITAL IMPAIRMENTS					
1. Clubfoot or any orthopedic problem (i.e., flat footed, etc.)	✓				
2. Harelip (cleft lip or cleft palate)	✓				
3. Down's Syndrome	✓				
4. Other Chromosome abnormality	✓				
5. Hydrocephalus	✓				
6. Muscular dystrophy	✓				Parts of body involved? Age at onset?
7. Dwarfism	✓				
8. Spina bifida	✓				
9. Congenital heart defect	✓				
10. Sickle Cell Anemia	✓				
11. Tay-Sachs disease	✓				
B ALLERGIES					
1. Eczema or other skin condition				Yes – little Sister	To what allergies? What treatment or medication?
2. Hay fever or other allergy	✓				
3. Drug allergy	✓				To what drugs?
4. Food allergy	✓				To what foods?
C EYE, DENTAL, EAR AND DEVELOPMENTAL DISORDERS					
1. Blindness, glaucoma, color blindness or other visual problems	✓				
2. Corrective glasses or contact lenses	✓				At what age were prescription lenses necessary? 13 years old
Nearsighted ☐ Farsighted ☑	✓		X		
Astigmatism (Inability to focus) ☐	✓				
Strabismus (Cross-eyed) ☐	✓				
Other (explain) ☐	✓				
3. Braces on teeth or other orthodontia work	✓				If so, what orthodontic work and for how long?

I. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (Continued)

MEDICAL CONDITION	NO	Not Known	YES Self	YES – RELATIVE *(Specify relationship)*	COMMENTS
4. Deafness or other ear problems					Special education? If "Yes", indicate age at onset.
5. Speech problems					
6. Learning disability					Any diagnosis? Hospitalization?
7. Retardation: mental or physical					
D CIRCULATORY DISORDERS 1. Hemophilia					
2. Sickle cell anemia or trait					
3. Hypertension (high blood pressure)					Age at onset? What treatment? Hospitalization?
4. Stroke					
5. Heart attack (coronary)					
6. Arthritis					What kind? Age at onset? What part of body?
7. Kidney disease					Age at onset? What treatment?
E HORMONAL DISORDERS 1. Diabetes					Age at onset? What treatment?
2. Thyroid disorder					
3. Obesity (overweight)					
F RESPIRATORY DISORDERS 1. Asthma					Any (known) cause? What treatment?
2. Emphysema					Age at onset?
3. Tuberculosis					Age at onset? What kind? What part of body?
G MENTAL AND BEHAVIORAL DISORDERS 1. Diagnosed schizophrenia					Age at onset? What treatment? Hospitalization?
2. Diagnosed manic depressive					
3. Other mental illness. Describe, using additional page, if necessary					
4. Alcoholism or heavy drinking					
5. Drug usage					Kind, amount, and when taken?

I. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (Continued)

MEDICAL CONDITION	NO	Not Known	YES Self	YES – RELATIVE *(Specify relationship)*	COMMENTS
H LYMPHATIC DISORDERS					What kind? Age of onset? What part of body?
1. Cancer	✓				
2. Tumors	✓				
3. Cystic fibrosis	✓				
4. Hodgkin's disease	✓				
I NERVOUS SYSTEM DISORDERS					Parts of body involved? Age at onset?
1. Multiple sclerosis	✓				
2. Huntington's disease	✓				
3. Cerebral palsy	✓				
4. Seizures or convulsions	✓				Age at onset? What treatment? Frequency?
5. Epilepsy	✓				
J INFECTION, HOSPITALIZATION					Diagnosis?
1. Repeated attacks of fever with known infection	✓				
2. Repeated severe infection necessitating hospitalization	✓				
3. Hospitalization, operation, or injury	✓				What for? When?
K OTHER MEDICAL OR HEALTH PROBLEMS					