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)

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)
5'0"	118	dark brown	dark	dark brown	☐ FINE ☐ MEDIUM ☐ COARSE ☐ STRAIGHT ☐ WAVY ☐ CURLY ☐ BALDING

BIRTHDATE (YEAR ONLY)	BIRTHPLACE (STATE ONLY)	BLOOD TYPE	RH FACTOR	BODY TYPE	ARE YOU RIGHT HANDED ☑
2060	NV			☒ 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)

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

African American

B. EDUCATION:

LAST GRADE COMPLETED	PRESENTLY IN SCHOOL	USUAL GRADES IN SCHOOL	OTHER TRAINING
11th	☐ YES ☒ NO		

EXTRA CURRICULAR ACTIVITIES

SUBJECTS INTERESTED IN

C. OCCUPATION:

PRESENT OCCUPATION	HOW LONG?	USUAL OCCUPATION
not employed		

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

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.

introvert

DESCRIBE TALENTS, HOBBIES AND GOALS IN LIFE.

DESCRIBE HOW YOU WERE AS A CHILD

E. ADOPTION QUESTIONS:

Religion:

What Religion do you practice: Christian

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?

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.)

toxic home life
not financially stable
needs to get "life together 4

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?

"Don't mind!

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

1. MENSTRUAL HISTORY

HOW OLD WERE YOU WHEN YOU BEGAN TO MENSTRUATE? 10

WHAT IS THE USUAL LENGTH OF YOUR PERIOD? 3 days

ARE YOU REGULAR? ☒ YES ☐ NO

NO. OF DAYS IN CYCLE 28

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 STREET | CITY, | STATE | ZIP CODE

WHEN DID PRENATAL CARE BEGIN? Aug 2024

WHAT WAS YOUR AGE WHEN YOU BECAME PREGNANT? 20

NUMBER OF WEEKS THIS PREGNANCY? 37

TYPE OF BIRTH ☒ 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 None

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:

a. Prescription Drugs: [Give name(s)]	TAKEN DURING THIS PREGNANCY (Check √ under appropriate column) YES	NO	TAKEN WITHIN ONE YEAR PRIOR TO PREGNANCY YES	NO	WHEN?	HOW OFTEN?	AMOUNT?
1. None							
2.							
3.							
4.							
b. Nonprescription Drugs. Including aspirin, nose drops, etc.							
1. None							
2.							
3.							
4.							
c. Alcohol and other substances:							
1. Alcohol (wine, beer, etc)		✓		✓			
2. Amphetamines (uppers)		✓		✓			
3. Barbiturates (downers)		✓		✓			
4. Tobacco	✓		✓				
5. Cocaine		✓		✓			
6. Crack		✓		✓			
7. Heroin		✓		✓			
8. LSD		✓		✓			
9. PCP		✓		✓			
10. Marijuana		✓		✓			
11. Other (specify)	✓		✓				

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

G. PERSONAL HEALTH HISTORY

DESCRIBE YOUR GENERAL HEALTH

good

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	unknown	53
If deceased, age at death		N/A
Cause of death		N/A
Height & Weight	HEIGHT WEIGHT	HEIGHT 5'8" WEIGHT unk
Hair color and texture		dark brown + gray
Eye color		dark brown
Skin color		dark
Left or right handed		right
Outstanding features		—
Education Completed		high school
Occupation		temp. workes - ward house
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		african american
Religion		Jehovah's Witness
Was this parent aware of your pregnancy?	☐ YES ☐ NO	☒ YES ☐ NO
How many brothers or sisters did she/he have?		3 sister 1 brother
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	unknown		unknown	
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) NONE

	1	2	3	4
Sex (Male or Female)	N/A			
Age				
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				
Eye color				
Skin color				
Hobbies and talents				
Last grade completed				
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				
Number of children they have				
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	N/A			
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.)	X				
2. Harelip (cleft lip or cleft palate)	X				
3. Down's Syndrome	X				
4. Other Chromosome abnormality	X				
5. Hydrocephalus	X				
6. Muscular dystrophy	X				Parts of body involved? Age at onset?
7. Dwarfism	X				
8. Spina bifida	X				
9. Congenital heart defect	X				
10. Sickle Cell Anemia	X				
11. Tay-Sachs disease	X				
B ALLERGIES					
1. Eczema or other skin condition	X				To what allergies? What treatment or medication?
2. Hay fever or other allergy	X				
3. Drug allergy	X				To what drugs?
4. Food allergy	X				To what foods?
C EYE, DENTAL, EAR AND DEVELOPMENTAL DISORDERS					
1. Blindness, glaucoma, color blindness or other visual problems	X				
2. Corrective glasses or contact lenses	X				At what age were prescription lenses necessary?
Nearsighted ☐ Farsighted ☐	X				
Astigmatism (Inability to focus) ☐	X				
Strabismus (Cross-eyed) ☐	X				
Other (explain) ☐	X				
3. Braces on teeth or other orthodontia work	X				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	X				Special education? If "Yes", indicate age at onset.
5. Speech problems	X				
6. Learning disability	X				Any diagnosis? Hospitalization?
7. Retardation: mental or physical	X				
D CIRCULATORY DISORDERS					
1. Hemophilia	X				
2. Sickle cell anemia or trait	X				
3. Hypertension (high blood pressure)	X				Age at onset? What treatment? Hospitalization?
4. Stroke	X				
5. Heart attack (coronary)	X				
6. Arthritis				X	What kind? Age at onset? What part of body? Mom
7. Kidney disease	X				Age at onset? What treatment?
E HORMONAL DISORDERS					
1. Diabetes				X	Age at onset? What treatment? Dad
2. Thyroid disorder	X				
3. Obesity (overweight)	X				
F RESPIRATORY DISORDERS					
1. Asthma			X		Any (known) cause? What treatment?
2. Emphysema	X				Age at onset?
3. Tuberculosis	X				Age at onset? What kind? What part of body?
G MENTAL AND BEHAVIORAL DISORDERS					
1. Diagnosed schizophrenia	X				Age at onset? What treatment? Hospitalization?
2. Diagnosed manic depressive				X	Aunt
3. Other mental illness. Describe, using additional page, if necessary	X				
4. Alcoholism or heavy drinking				X	both sides of family
5. Drug usage				X	Kind, amount, and when taken? both sides of family

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				X	Non-cervical cancer
2. Tumors	X				
3. Cystic fibrosis	X				
4. Hodgkin's disease	X				
I NERVOUS SYSTEM DISORDERS					Parts of body involved? Age at onset?
1. Multiple sclerosis	X				
2. Huntington's disease	X				
3. Cerebral palsy	X				
4. Seizures or convulsions	X				Age at onset? What treatment? Frequency?
5. Epilepsy	X				
J INFECTION, HOSPITALIZATION					Diagnosis?
1. Repeated attacks of fever with known infection	X				
2. Repeated severe infection necessitating hospitalization	X				
3. Hospitalization, operation, or injury	X				What for? When?
K OTHER MEDICAL OR HEALTH PROBLEMS					