INFORMATION ABOUT YOUR FAMILY HISTORY – Father's

Your Child's Name:	
Child's date of birth:	
Father's Name (last, first, middle)	
Person completing form, if not father	
Relationship to father:	

FATHER'S BACKGROUND

Date of birth:			
Place of birth:			
Where did you grow up?			
Previous name(s):			
Social Security Number:			
Driver's License Number:		State that issued license:	
Ethnic background (examples: Irish-American, Italian on mother's side, German on father's side, Chinese)			
Membership in a federally-recognized Native American tribe:		Myself: ☐ Yes ☐ No	My child: ☐ Yes ☐ No
If so, which tribe?			
If you have a religious affiliation, what is it? (Examples: Jewish, Christian, Catholic, Muslim)			
What is your present address?		Mailing address if different	
Please provide the name and address of a person who is likely to know where you are if you move:			

Please return to: Vermont Adoption Registry, 280 State Dr., Waterbury, VT 05671

YOUR PHYSICAL DESCRIPTION

Height:	Weight:
Complexion:	Natural Hair color:
Eye color:	
If you have distinguishing marks, such as birthmarks, scars or tattoos, please describe:	

EDUCATION AND EMPLOYMENT HISTORY

Please list all schools that you attended:

School	School Address	Last grade completed	Years attended

Tell us about your school experience: _____

_____

_____

_____

_____

Please describe your past and present work experience: _____

_____

_____

_____

_____

_____

Present occupation: _____

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Have you been in the military? ☐ Yes ☐ No. If so, what branch?_____

What was your rank and serial number? _____

YOUR PAST/PRESENT MARRIAGES AND DIVORCES

Name of Spouse: (last name) (first name) (middle name)	Marriage		Divorce	
	Date	Place	Date	Place

YOUR PERSONALITY, INTERESTS AND TALENTS

Please tell us a little about yourself:_____

_____

_____

_____

_____

_____

What are your interests and talents? (Examples: artistic, mechanical, athletic, like science, musical, etc.) _____

_____

_____

_____

What are your plans for the future? _____

_____

_____

Is there anything else you would like to add about your personal history:_____

_____

_____

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YOUR FAMILY

Your mother's name (last, first, middle):			
Date of birth:	Height:	Weight:	Hair color:
Eye color:	Race:	Ethnic background:	
Level of education		Occupation:	
General health:		If deceased, what year did she die and what was the cause?	
Is your mother aware of this child?			

Your father's name (last, first, middle):			
Date of birth:	Height:	Weight:	Hair color:
Eye color:	Race:	Ethnic background:	
Level of education		Occupation:	
General health:		If deceased, what year did she die and what was the cause?	
Is your father aware of this child?			

INFORMATION ABOUT YOUR BROTHERS AND SISTERS

Name: (last) (first) (middle)	Male or Female	Date of Birth	Last known Address	Last Grade Completed	Occupation	Deceased Y/N

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YOUR CHILD'S HISTORY

Child's Full Name: _____

(first name) (middle name) (last name)

Date of Birth: _____ Time of Birth: _____

Place of Birth: _____

(Town) (State) (Country)

Was your child named after someone special? ☐ Yes ☐ No

If yes, who? _____

YOUR CHILD'S MEDICAL INFORMATION

Who has your child's immunization records? _____

What illnesses has your child had?(check all that apply)

- ☐ Chicken Pox
- ☐ Bladder or kidney infections
- ☐ Mumps
- ☐ Ear infections
- ☐ Whooping cough
- ☐ Frequent nausea or vomiting
- ☐ Hepatitis
- ☐ Frequent diarrhea or constipation
- ☐ Meningitis
- ☐ Red measles
- ☐ Sore throats
- ☐ Allergies
- ☐ Hospitalizations
- ☐ Major operations, illnesses or accidents
- ☐ Seizures or convulsions
- ☐ Headaches
- ☐ Rash/.skin problems
- ☐ Dizziness
- ☐ Asthma, hay fever
- ☐ Broken Bones
- ☐ Fainting
- ☐ Dental Cavities
- ☐ Pneumonia
- ☐ Frequent swollen glands
- ☐ Rheumatic Fever
- ☐ Trouble urinating
- ☐ Anemia
- ☐ Frequent bruises or bleeding
- ☐ Jaundice

If your child has had other illnesses or if you checked any of the above, please describe: _____

_____

_____

_____

_____

_____

_____

_____

Please return to: Vermont Adoption Registry, 280 State Dr., Waterbury, VT 05671

YOUR CHILD'S CURRENT AND PAST DOCTORS:

Current Doctor	
Name:	Address:
Past Doctors	
Name:	Address:
Name:	Address:
Name:	Address:

YOUR CHILD'S EDUCATION

How does your child do in school? _____

If your child has special educational needs, what are they? _____

_____

_____

_____

CHILD'S SPECIAL NEEDS

If your child has been formally evaluated for any special problems, what was the evaluation for?

☐ Medical problem

☐ Dental or orthodontic

☐ Emotional disturbance or mental illness

☐ Learning/school problems

☐ Other: what kind? _____

If yes, who did the evaluation? _____

When was the evaluation done? _____

Has your child ever lived with relatives or other place away from home, please describe: _____

_____

_____

_____

BROTHERS AND SISTERS OF YOUR CHILD

(Include brothers, sisters, step-brothers and step-sisters living at home or elsewhere, 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 your child	Who is caring for this child?

Describe your child's relationship with these brothers and sisters? _____

_____

_____

_____

_____

YOUR HEALTH HISTORY

Have you ever had a formal evaluation any of the following reasons?

☐ Medical problem ☐ Dental or orthodontic

☐ Emotional disturbance or mental illness ☐ Learning/school problems

☐ Other: what kind? _____

If yes, who did the evaluation? _____

When was the evaluation done? _____

YOUR 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 in the box. 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.

Physical Concerns

Condition	Self	Other family member	What relationship? Examples: mother, sister, grandfather)
Acne or pimples			
Alcohol abuse/alcoholism			
Allergies to Food. If so, what foods?			
Allergies to other things. If so, what allergies?			
Alzheimer's			
Anemia (low iron)			
Arthritis			
Asthma			
Bedwetting			
Birth Defects. What kind?			
Braces on Teeth			
Bronchitis			
Cancer. What kind?			
Cleft lip or palate			
Club foot			
Colitis			
Cystic Fibrosis			
Dental Problems What kind? (ex: tooth decay, gum problems)			
Deafness/hearing problems			
Diabetes (juvenile) Type I			

Condition	Self	Other family member	What relationship? Examples: mother, sister, grandfather)
Diabetes (adult) Type II			
Down's Syndrome			
Dwarfism/ very short height			
Ear infections			
Eczema			
Emphysema			
Epilepsy or seizures			
Eye problems. What kind? Ex: glasses, glaucoma, color blindness)			
Very tall height			
Gynecological (female) problems. What kind? (Ex: heavy periods, early menopause)			
Headaches or migraines			
Heart attack or heart problems			
Hemophilia or bleeding			
Hepatitis			
Hives			
High blood pressure			
Huntington's Chorea			
Infertility/difficulty getting pregnant			
Jaundice or yellow skin			
Kidney disease			
Learning problems or disabilities			
Liver disease			
Lung problems			
Lupus			
Miscarriages			
Muscular Dystrophy			
Obesity/significant overweight			

Condition	Self	Other family member	What relationship? Examples: mother, sister, grandfather)
Osteoporosis/brittle bones			
Paralysis			
Rectal or intestinal polyps			
Rheumatic fever			
Sickle cell anemia			
Skin disease			
Speech problems. What kind? (Ex: stutters, lisps)			
Stillbirths			
Stomach problems. What kind?			
Stroke			
Surgery. What for?			
Tay-Sachs Disease			
Thyroid problems			
Twins or multiple births			
Varicose Veins			
Other			
Other			
Other			

Emotional Concerns

Condition	Self	Other family member	What relationship? Examples: mother, sister, grandfather)
Bi-polar illness (manic depression)			
Drug Abuse			
Schizophrenia			
Depression			
Other Mental Illness. What kind?			

Sexually Transmitted Diseases

Condition	Myself	My child's other parent	Condition	Myself	My child's other parent
Chlamydia			HIV Infection/AIDS		
Genital Warts			Syphilis		
Gonorrhea			Other		
Herpes			Other		

If you checked other under any category, please explain: _____

_____

_____

_____

_____

_____

_____