

SAFE HAVEN MEDICAL QUESTIONNAIRE



Dear Birth Mother:

You have taken the first step in assuring that your child will be safe and well taken care of. We know this has been a very difficult decision for you, and we want to assure you that we will give your child the best possible care.

We are asking for your help by providing some health information that may be important for your child to know in his or her future. This information is important for your child's care, and will be most helpful for the adoptive family. The information will be used only for this purpose. It will not

be used to identify you or find you. You may not know all of the answers - Please provide as much information as you do know.

What is the baby's birth date? _____ Was the baby premature? _____ If yes, when was the approximate date you became pregnant? _____

Were there any problems with the pregnancy or delivery? If yes, please describe:

Did you smoke, use alcohol, drugs or any medication during the pregnancy? If yes, please list them:

Do you have any medical conditions such as:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Other (explain) |
| <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Mental Illness | |

Does the baby's Father have any medical conditions such as:

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eye problems |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Other (explain) |
| <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Mental Illness | |

What is your:

Age: _____ Race: _____

Height: _____ Weight: _____

What it is the baby's father's

Age: _____ Race: _____

Height: _____ Weight: _____

To your knowledge are there any hereditary conditions that run in your family, or the father's family?

Please feel free to include a note to your baby, or to the people who will adopt your child. You can use the back of this form.

You have given your baby a special gift by providing this medical information. You have taken good care of your baby; now please take care of yourself. It is now important that you personally get a medical check-up – you will remain anonymous, just as the law allows. We can assist you.