

THE STATE OF NEW HAMPSHIRE

JUDICIAL BRANCH

<http://www.courts.state.nh.us>

Court Name: _____

Case Name: _____

Case Number: _____
(if known)

MEDICAL INFORMATION ON BIRTH PARENTS

☐ Birth Mother ☐ Birth Father (Use separate form for each parent.)

For each of the medical conditions described below, please check the appropriate column indicating whether you or any blood relative (i.e. your mother, father, sisters, brothers, grandparents, aunts, uncles or any other children you have had) ever had, or now have, the condition listed. Complete the "Comments" section as needed using a separate sheet of paper if additional space is required.

MEDICAL CONDITION	NO	NOT KNOWN	YES (SELF)	YES (RELATIVE)	COMMENTS
1. Club Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Harelip, cleft lip, or cleft palate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Any other malformations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Part of body involved? Age at onset?
6. Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Other paralysis or crippling disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Seizures, convulsions or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age at onset? What Treatment? Frequency?
10. Blindness, glaucoma or other visual problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age at onset? Cause? Special Education?
11. Deafness or other ear problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Speech problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age at onset? Cause? Special Education?
13. Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Retardation: mental or physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any diagnosis or cause? Hospitalized?
15. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age at onset? Treatment?
16. Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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MEDICAL CONDITION	NO	NOT KNOWN	YES (SELF)	YES (RELATIVE)	COMMENTS
17. Other hormone disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Eczema or other skin conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any cause known? What treatment? Medication?
19. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Hay fever or other allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age at onset? Treatment? Hospitalization?
22. Manic depressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. Other mental or emotional illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26. Heart attack (Coronary)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27. Other cardiovascular problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What kind? Age at onset? What part of body?
29. Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
30. Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
31. Huntington's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
32. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
33. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Age of onset? Treatment?
34. Alcoholism or heavy drinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
35. Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kind, amount and when taken.
36. Hospitalization, operation, or injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
37. Any other conditions you or others in your family might have	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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MEDICAL INFORMATION ON BIRTH PARENTS

OTHER INFORMATION ON BIRTH PARENTS

Information given should be as of the time of the child's birth. Do not include any identifying information.

Height	Weight	Body build
Eye color	Hair color	Skin color
Age	Race	Nationality (citizenship)
Ethnic background	Religion	No. of school years completed
Future education goals		
General field of occupation		
Talents, hobbies and special interests		
Future aspirations		
Relationship between parents		
Number of other female children born to you		Ages
Number of other male children born to you		Ages

BIRTH MOTHER ONLY

MENSTRUAL AND PREGNANCY HISTORY

Age at onset of menses	_____	Are periods regular?	_____	Usual length of period	_____
				No. of days between periods	_____

List all pregnancies in order. Use one line for each child, miscarriage, abortion or still-birth.

CHILDREN (Write baby girl, baby boy, miscarriage, still-birth or abortion.)	HOW MANY MONTHS DID YOU CARRY THIS PREGNANCY?	YEAR IN WHICH PREGNANCY ENDED	IF MISCARRIAGE OR ABORTION, WAS IT NATURAL OR INDUCED?
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MEDICAL INFORMATION ON BIRTH PARENTS

INFORMATION ON THIS PREGNANCY

Is the baby's father aware of this pregnancy? ☐ Yes ☐ No

Is the baby's father a genetic relative of yours? ☐ Yes ☐ No

If yes, how is he related? _____

Month prenatal care began for this pregnancy _____

Complications, if any _____

Exposure during pregnancy: ☐ X-Ray ☐ Electrocardiogram ☐ Radiation

Prescription drugs taken during pregnancy	When	Amount and frequency
Kind		

Non-prescription drugs taken during pregnancy	When	Amount and frequency
Kind		

Did you use alcohol during pregnancy? ☐ Yes ☐ No Amount and frequency

Amphetamines (Uppers) used during pregnancy	When	Amount and frequency
Kind		

Barbiturates (Downers, cocaine, heroin, LSD, marijuana, cigarettes) used during pregnancy	When	Amount of frequency
Kind		

CHILD'S BIRTH HISTORY

Child's first name	Sex	Date of birth
Time of birth	Place of birth	Weight
Length	Eye color	Hair color
Complexion	Head circumference	Chest circumference
Physical appearance including abnormalities		

Term Premature _____ weeks Postmature _____ weeks Full term _____ weeks

Mother's blood type RH factor Baby's blood type

Type of delivery Anesthesia used Duration of labor

Apgar score at 1 minute Apgar score at 5 minutes

Condition of child at birth