



**Thank you for bringing your baby to a Safe Haven. You have taken the first step in assuring that your baby will be safe. This has been a difficult decision for you, and we want to assure you that we will do what we can to give your baby the best possible care. Please assist us by providing some health information that will be important to your baby's future. The information is used only to assist your baby and the adoptive family, not to identify or locate you. You may not know all of the answers, so just provide as much information as you do know.**

1. What is your baby's birth date? \_\_\_\_\_
2. Did the mother receive any prenatal care? Yes/No What month did prenatal care start? \_\_\_\_\_
3. Were there any problems with the pregnancy or delivery? Yes/No
4. If yes, please describe what happened.

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5. Does your baby have any siblings? Yes/No How many? \_\_\_\_\_
6. Is either parent of Native American ancestry? Yes/No What tribe? \_\_\_\_\_
7. Is there anything else you would like to add?

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**Birth Mother**

**Birth Father**

Age:	Age:
Race:	Race:
Religion:	Religion:
Hair Color:	Hair Color:
Eye Color:	Eye Color:
Height:	Height:
Weight:	Weight:
Education:	Education:

8. Drugs taken during this pregnancy:

	Yes	No		Yes	No
Alcohol			LSD		
Amphetamines			PCP		
Tobacco			Marijuana		
Cocaine			Prescription Drug		
Crack			Club Drugs		
Crank			IV drug use		
Heroin					

9. Do parents or family members have any of the following medical conditions? Which parent?

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Hepatitis/Jaundice
<input type="checkbox"/> Allergies	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Breast/Ovarian Cancer	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Polio
<input type="checkbox"/> Depression	<input type="checkbox"/> Seizures
<input type="checkbox"/> Developmental Disabilities	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Testicular Cancer
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Vision Problems