THE LAW OFFICES OF MARY BECK LLC
PRACTICE LIMITED TO ADOPTION & SURROGACY
FELLOWS OF THE ACADEMY OF ADOPTION & ASSISTED REPRODUCTION
ATTORNEYS

BIRTH MOTHER'S SOCIAL & FAMILY HISTORY

Name (first, middle, last): _____

Maiden Name: _____ Birthdate: _____

Social Security # _____

Birthplace _____

Driver's License #: _____ State: _____

Current Address:
_____

How Long at This Address: _____

Permanent Address (If different)
_____

Home Phone (with area code) _____

Can we leave identifying messages at home? Yes ☐ No ☐
If not, please give us a phone number where we can leave messages for you:
_____

Where did you grow up (city/town & state)?
_____

I am married: Yes ☐ No ☐

If yes: My husband's name: _____

If no: ☐ I have never been married ☐ I was divorced _____ (month and year)

BIRTH MOTHER'S RACE/ETHNICITY

Were you or any member of your immediate family adopted? Yes ☐ No ☐
If yes, specify which family member(s)
_____

Race (check all that apply)
☐Caucasian/White ☐ African-American ☐ American Indian ☐ Asian ☐Hispanic
☐ Native Hawaiian or other Pacific Islander ☐ Alaskan Native ☐ Filipino ☐ Other: _____

Nationality/Ethnic Background (e.g., Irish, Mexican, Nigerian, Russian, Chinese)

_____

Are you a citizen of the United States? Yes ☐ No ☐
Are you a permanent resident (with a green card) of the United States? Yes ☐ No ☐
Do you have a passport or visa number? _____

NATIVE AMERICAN-INDIAN TRIBAL MEMBERSHIP

To your knowledge, is there any American Indian heritage in your family? Yes ☐ No ☐

If you have any American Indian heritage, describe the blood relation and tribe (e.g., my father was one-half Arapaho, my maternal grandmother was one-eighth Sioux)

_____

_____

Are you a member of any Native American Indian tribe? Yes ☐ No ☐
Do you qualify to be a member of any Native American Indian tribe? Yes ☐ No ☐

If yes, please indicate the tribe, location and your registration, enrollment or registration number: _____

Do you currently or have you ever lived on an American Indian reservation? Yes ☐ No ☐
Are any of your relatives members of any Native American Indian tribes? Yes ☐ No ☐

Do any of your relatives qualify to be members of any Native American Indian tribes?
Yes ☐ No ☐
If yes, please list the relative's name (including maiden or former names), address, registration/enrollment number, and the name and location of the tribe:

_____

_____

Have you, your parents, grandparents or any other ancestor ever had a Certificate of Degree of Indian Blood (CDIB)? Yes ☐ No ☐
If yes, please attach a copy of the CDIB to this questionnaire

EMPLOYMENT INFORMATION

Are you currently employed? _____ If yes, type of job _____

Name & address of employer _____

Work Phone (with area code) _____
Can we contact you at work? Yes ☐ No ☐
Do you like your job? Yes ☐ No ☐ Do you like your boss? Yes ☐ No ☐

Is your employer aware of your plan for adoption? Yes ☐ No ☐

Previous Employment (type of job and dates of employment): _____

_____

Career Goals: _____

EDUCATION

Number of years attended: Grade School Completed/graduated? Yes ☐ No ☐

"Held back" in school? Yes ☐ No ☐ "Skipped ahead" in school? Yes ☐ No ☐

High School Completed/graduated? Yes☐ No ☐ Grades ☐ High ☐ Average ☐ Poor ☐

How would you describe your high school experience? _____

_____

College _____ Major _____

Completed/graduated? Yes ☐ No ☐

How would you describe your college experience? _____

_____

Vocational or other Training: ? _____

Did you like school? Yes ☐ No ☐ Did you have a lot of friends in school? Yes ☐ No ☐

Did you make friends easily? Yes ☐ No ☐

In which of the following subjects did you make good grades (check all that apply)?

Reading ☐ Math ☐ Science☐ History☐ Spelling☐ English☐ Foreign language☐

Social Studies☐ Art ☐ Drama ☐Sports☐

In which of the following subjects did you make poor grades (check all that apply)?

Reading ☐ Math ☐ Science☐ History☐ Spelling☐ English☐ Foreign language☐

Social Studies☐ Art ☐ Drama ☐ Sports☐

Academic or Educational Achievements/Awards? _____

_____

Educational Goals: _____

_____

MILITARY HISTORY

Have you ever served in the military? Yes ☐ No ☐
If yes, please specify what branch of the service: _____
Dates of service: _____
Rank & serial number: _____

CRIMINAL HISTORY

Please provide the following information about all arrests or convictions for crimes other than minor traffic infractions: crime, year of conviction, sentence (fine or jail; if jail length of incarceration)

_____
_____

_____

Are you currently on probation or parole? Yes ☐ No ☐
If yes, please specify for how long, who you report to, and when you report

_____

_____

RELIGION

Do you practice any religion or attend any religious services? Yes ☐ No ☐
If yes, please specify what religious order_____

INTERESTS/TALENTS/HOBBIES

Please give a brief description of what your interests are now. Describe your hobbies, special talents or abilities. What are your personal goals at this time?

_____

_____

_____

Do other members of your family (grandparents, parents, children) have similar hobbies, special talents or abilities? Please describe

_____

_____

_____

Do you speak or write any languages other than English?
If so, what other languages? _____

Were you involved in any school activities or sports? Yes ☐ No ☐
If so, describe _____

How would you describe your personality as a child, your usual behavior, attitudes, moods, favorite activities, types of people you enjoyed being with, etc.

_____

_____

_____

What would you like this child to know about you and your family?

_____

_____

_____

Birth Mother's Other Children
(Siblings of Child to be Adopted)

	Sibling #1	Sibling #2	Sibling #3	Sibling #4
Name				
Sex				
Full or half sibling	Full ☐ Half ☐	Full ☐ Half ☐	Full ☐ Half ☐	Full ☐ Half ☐
Does this child live with you?	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No ☐	Yes ☐ No☐
Age or Year of Birth				
General health	Good ☐ Fair ☐ Poor ☐	Good ☐ Fair ☐ Poor ☐	Good ☐ Fair ☐ Poor ☐	Good ☐ Fair ☐ Poor ☐
Major surgery?				
Health problems?				
If deceased, age at, cause				
Race, Nationality				
Education				
Special Hobbies Talents				
Occupation				
Height				
Weight				
Hair Color				
Eye Color				
Complexion (skin tone)				
Was/Is this child aware of your pregnancy?	Yes ☐ No☐	Yes ☐ No☐	Yes ☐ No ☐	Yes ☐ No ☐
Personality				

Birth Mother's Extended Family

If more than 2 sisters or brothers use additional paper

	Your Mother	Your Father	Your Sister or Brother #1	Your Sister or Brother #2
Name				
Age or Year of Birth				
If deceased, age & cause				
Race, Nationality				
Education				
Special Hobbies or Talents				
Occupation				
Height				
Weight				
Hair Color				
Eye Color				
Complexion (skin tone)				

Please give a brief description of your childhood home, relationship with your parents and siblings and family life _____
_____

Are you a twin or triplet? _____ Identical or Fraternal? _____

BIRTH FATHER

The father of my child is: _____

He knows that I am pregnant: Yes ☐ No ☐

Birth Mother's Grandparents

	Your Mother's Mother	Your Mother's Father	Your Father's Mother	Your Father's Father
Name				
Age or Year of Birth				
If deceased, age & cause				
Race, Nationality				
Education				
Special Hobbies or Talents				
Occupation				
Height				
Weight				
Hair Color				
Eye Color				
Complexion (skin tone)				

Please give a brief description of your relationship with your grandparents and what their home was like._____
_____

Do you have any family members who are/were very special in your life? Why?
_____
_____

The above information is true and accurate to the best of my knowledge

_____
Signature

_____ _____
Print Name **Date**

Birth Mother's Pregnancy History

MOTHER'S BIRTH HISTORY

Your weight at birth _____ Your length at birth _____

Full term ☐ Premature ☐ Postmature ☐
Vaginal (normal) delivery ☐ Caesarian (C-Section) ☐
Any complications with your delivery or birth? Yes ☐ No ☐

If yes, please describe: _____

PREGNANCY HISTORY

Is this your first pregnancy? Yes ☐ No ☐ If no, how many prior pregnancies? _____

At what age did you get your first menstrual period? _____

Please indicate what occurred with prior pregnancies: (indicate #)

Abortion: _____ Miscarriage: _____

Birth: _____ Vaginal delivery: _____ C-Section: _____

Were there any problems or complications with prior pregnancies or births? Yes ☐ No ☐
If yes, please describe: _____

Were any of your other children/pregnancies premature? Yes ☐ No ☐

Were any of your other children multiple births (twins or triplets)? Yes ☐ No ☐

PREGNANCY INFORMATION

Last menstrual period? _____ Age When You Became Pregnant: _____

Due date:_____ Date When You Realized You Were Pregnant: _____

Has your pregnancy been confirmed by testing (other than a home test)? Yes ☐ No ☐
If yes, when and where: _____

Do you know the gender of this baby: No ☐ Yes ☐ the baby is a girl ☐ boy☐

Have you ever used birth control ?_____Type and duration of use: _____

Were you using birth control when you became pregnant? Yes ☐ No ☐
If yes, please indicate what type: _____

Did you have any food cravings during this pregnancy? Yes ☐ No ☐
If yes, please describe: _____

Within the 30 day period before or after conceiving your baby with the Birth Father, did you have intercourse with anyone else? Yes ☐ No ☐

Are you biologically related to the father of this child? Yes ☐ No ☐
If yes, how? _____

What is the race/ethnicity of your baby? (check **all** that apply)
☐ Caucasian/White ☐ African-American ☐ Hispanic or Latino
☐ American Indian ☐ Asian ☐ Native Hawaiian or other Pacific Islander
☐ Alaskan Native ☐ Unable to Determine ☐Other_____

If Native American (American Indian) or Alaskan Native, specify name of tribe and degree of Indian blood if known_____

Have you been involved in any accidents during this pregnancy? Yes ☐ No ☐
If yes, please describe in detail: _____

Has anyone hit you, knocked you down or shoved you during this pregnancy? Yes ☐ No ☐
If yes, please describe in detail, including whether you called the police or got medical attention:_____

To your knowledge, were you exposed to lead or mercury during this pregnancy?
Yes ☐ No ☐ If yes, please describe: _____

Have you had excessive bleeding during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had any kidney or bladder infections during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had any operations during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had any convulsions during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

Have you had *any* complications during this pregnancy? Yes ☐ No ☐
If yes, please explain: _____

If you are currently employed, do you plan to stop working prior to the birth of this child?
Yes ☐ No ☐

LABOR AND DELIVERY INFORMATION

Are you seeing a doctor during this pregnancy? Yes ☐ No ☐

If yes, Doctor's Name/name of practice: _____
Address: _____
Phone w/ area code: _____

If applicable, when did you first see a doctor for prenatal care? _____

How many prenatal visits have you had? _____
How much weight have you gained during pregnancy? _____

Please list all doctors, medical providers, counselors or social workers who have provided treatment or care to you and/or the child (include name, address, and telephone number). Use additional pages if needed

_____
_____
_____
_____

Does your doctor know you are considering adoption? Yes ☐ No ☐

At which hospital will you be delivering?

Name _____

Address: _____

Phone w/ area code: _____

Have you registered with the hospital yet? Yes ☐ No ☐

Are you aware of their policies regarding adoption? Yes ☐ No ☐

Have you spoken with anyone at the hospital about your adoption plan? Yes ☐ No ☐
If yes, please list their name and their position or title _____

TESTS DURING PREGNANCY

Amniocenteses	Yes ☐	No ☐	Date_____	Result_____
Sonogram	Yes ☐	No ☐	Date_____	Result_____
Blood Test	Yes ☐	No ☐	Date_____	Result_____
VDRL Screening	Yes ☐	No ☐	Date_____	Result_____
AIDS Test	Yes ☐	No ☐	Date_____	Result_____
X-Rays	Yes ☐	No ☐	Date_____	Result_____
EKG	Yes ☐	No ☐	Date_____	Result_____
Radiation	Yes ☐	No ☐	Date_____	Result_____
Tuberculosis	Yes ☐	No ☐	Date_____	Result_____
Other tests	Yes ☐	No ☐	Date_____	Result_____

If some or all of the above tests have been completed, please ask your doctor to forward a copy of the results to us. Please ask your doctor to send a letter stating your estimated date of delivery and your general health.

CONDITIONS DURING PREGNANCY OR WITHIN FIVE YEARS BEFORE PREGNANCY

Rubella/Measles	Yes ☐ No ☐	Date_____Treatment_____
Gonorrhea	Yes ☐ No ☐	Date_____Treatment_____
Vaginal Warts	Yes ☐ No ☐	Date_____Treatment_____
Virus	Yes ☐ No ☐	Date_____Treatment_____
Infections	Yes ☐ No ☐	Date_____Treatment_____
Chlamydia	Yes ☐ No ☐	Date_____Treatment_____
Herpes	Yes ☐ No ☐	Date_____Treatment_____
Cytomegalovirus	Yes ☐ No ☐	Date_____Treatment_____
Parvovirus	Yes ☐ No ☐	Date_____Treatment_____
Syphillis	Yes ☐ No ☐	Date_____Treatment_____
Toxoplasmosis	Yes ☐ No ☐	Date_____Treatment_____
Varciella	Yes ☐ No ☐	Date_____Treatment_____
Cancer Therapy	Yes ☐ No ☐	Date_____Treatment_____
HIV/AIDS	Yes ☐ No ☐	Date_____Treatment_____
Allergies	Yes ☐ No ☐	Date_____Treatment_____
Hepatitus	Yes ☐ No ☐	Date_____Treatment_____

MEDICAID INFORMATION

Do you have Medicaid? Yes ☐ No ☐

If no, are you eligible and willing to apply? Yes ☐ No ☐
If yes, date applied and Medicaid number? _____

What state/county is your Medicaid issued through? _____

Date benefits begin: _____

INSURANCE INFORMATION

Do you have medical insurance coverage? Yes ☐ No ☐

If yes, Company name: _____

Address: _____

Phone Number: _____

Policy Number: _____

If you know, what percentage of medical costs will your insurance company cover for this pregnancy? _____

DRUG & ALCOHOL USAGE	Not used in 5 years prior to pregnancy	Never Used During Pregnancy	Used occasionally (1-5 times) during pregnancy	Used monthly during pregnancy	Used weekly during pregnancy	Used daily during pregnancy
Aminopterin						
ACE Inhibitors						
Busulfan						
Sleeping pills						
Carbanazepine						
Cholorobiphenyls						
Cyclophosphamide						
Diethylstilbestrol						
Etretinate						
Iodine						
Acutane						
Lithium						
Phenobarbital						
Phenytoin						
Propylthiouracil						
Prostaglandin						
Tetracycline						
Valproic Acid						
Warfarin						
Steroids						
Fertility drugs						
Anti-Convulsants						
Medication for Diabetes						
Heart/Blood Pressure meds						
Pain Relievers, incl aspirin						

DRUG & ALCOHOL USAGE	Not used in 5 years prior to pregnancy	Never Used During Pregnancy	Used occasionally (1-5 times) during pregnancy	Used monthly during pregnancy	Used weekly during pregnancy	Used daily during pregnancy
Medicine for Nausea						
Antibiotics						
Antihistamines						
Hormones						
Cortisone (ATCH, etc.)						
Medication for Cancer						
Thalidomides						
Nose Drops or Spray						
Cigarettes						
Alcohol						
Marijuana						
Cocaine/Crack						
Amphetamines, incl. Meth						
Heroin						
Ecstasy						
Methadone						
LSD						
Stimulants						
Depressants						
Diet Pills						
Tranquilizers						
PCP (Angel Dust)						
Barbituates						
Caffeine (coffee, tea, etc.)						
Vitamin A, E, D (please specify)						

MEDICATION & DRUG/ALCOHOL USAGE

*Please be very specific as to any drugs or alcohol used during your pregnancy or in the last 5 years, including the frequency of usage. This information is very important for the prediction of your child's health. This information will be passed along to the adoptive family and to the child's pediatrician. Place an '**X**' in the applicable boxes and leave* blank all other boxes.

Please be specific about any prescription drugs used or prescribed during your pregnancy:

Name of drug: _____
Prescribed for: _____
Length used: _____

Name of drug: _____
Prescribed for: _____
Length used: _____

Name of drug: _____
Prescribed for: _____
Length used: _____

Did/do either of your parent(s) have a problem with drug or alcohol abuse? Yes ☐ No ☐
If yes, please explain: _____

Does/did this child's father have a problem with drug or alcohol abuse? Yes ☐ No ☐

If yes, please explain: _____

The above information is true and accurate to the best of my knowledge

_____
Signature

_____
Print Name

_____
Date

PHYSICAL CHARACTERISTICS & PREFERENCES

Eye Color: _____ Height: _____ Weight (before pregnancy): _____

Body Build: _____ Hair Color: ☐ Blonde ☐Brunette ☐ Red ☐ Other:

Texture ☐ Straight ☐Naturally Curly ☐Wavy ☐Fine ☐ Thick Style ☐ Long ☐Short

Complexion: ☐ Fair ☐ Olive ☐ Tan ☐Dark Is your skin sensitive? Yes ☐ No ☐

Do you have any allergic reaction to anything? Yes ☐ No ☐ Specify_____

Did you ever wear braces for your teeth, or told that you should? Yes ☐ No ☐

Do you wear glasses or contact lenses? Yes ☐ No ☐

If yes, what age did you start wearing them? _____

Are you right-handed or left-handed? Right ☐ Left ☐ ☐

Age when you started menstruation? _____ Problems (cramping or headaches)? Yes ☐ No ☐
If yes, describe: _____

Blood Type: _____ RH Factor: _____

PLEASE ATTACH A RECENT PHOTOGRAPH OF YOURSELF AND OF YOUR OTHER CHILDREN (IF ANY)

HEALTH HISTORY OF BIRTH MOTHER

Place an "X" if the listed medical condition exists in your medical history or if any relatives or other family members have/had any of the conditions. If one of your relative's deaths was the result of a particular medical condition, note it on the comments section to the right of the condition and write the age at which they died. *Use additional pages if needed*

Medical Condition	**You**	**Your mother**	**Your father**	**Your brother (s)or sister(s)**	**Your children**	**Indicate cause, treatment, medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please Indicate and other pages**
HIV/AIDS (medications prescribed)						
Breast Cancer (be specific, age at onset)						
Cervical Cancer (be specific, age at onset)						
Uterine Cancer (be specific, age at onset)						
Ovarian Cancer (be specific, age at onset)						
Bone Cancer (be specific, age at onset)						
Prostrate Cancer (be specific, age at onset)						
Lung Cancer (be specific, age at onset)						
Melanoma/ Skin Cancer (be specific, age at onset)						
Stomach Cancer (be specific, age at onset)						
Liver Cancer (be specific, age at onset)						
Pancreatic Cancer (be specific, age at onset)						
Brian tumor						
Other cancer (specify)						
Diabetes (insulin dependent? Adult or juvenile?)						
Ambiguous genitalia						
Osteoporosis						
Colitis						
Malnutrition						
Apnea Monitor						

Medical Condition	You	Your mother	Your father	Your brother/s or sister/s	Your children	More Information
Retardation: mental or physical (be specific)						
Down's Syndrome						
Turner's Syndrome						
Hydrocephalus (water on the brain)						
Microencephalus						
Other developmental disorders (be specific)						
Diagnosed schizophrenia						
Obsessive Compulsive Disorder						
Serious depression						
Repeated infections						
Lymphoma						
Neuro Tube Defect						
Fetal alcohol syndrome or effect						
Trisomy						
Wilson's Disease						
Gout						
Diagnosed manic depressive (medications prescribed)						
Sickle cell anemia or trait						
Cystic fibrosis						
Leukemia						
Club foot or any orthopedic problem						
Bed wetting						
Gynecological problems (specify)						

Medical Condition	You	Your mother	Your father	Your brother/s or sister/s	Your children	More Information
Dwarfism						
Spina Bifida						
Congenital heart defect (be specific)						
Tuberculosis						
Thyroid Disorder						
Hay fever						
Food allergy(s)						
Drug allergy(s) (name of drug(s))						
Other allergy(s) (be specific)						
Farsighted						
Nearsighted						
Astigmatism (inability to focus)						
Different color eyes						
Night blindness or color blindness						
Glaucoma						
Detached retina Blindness (cause of blindness)						
Cataracts or other visual problems (be specific)						
Strabismus (crosseye)						
Sinus or nasal problems						
Ear infections						
Deafness (cause of deafness)						
Other ear problems						

Medical Condition	You	Your mother	Your father	Your brother/s or sister/s	Your children	More Information
Teeth problems (excessive cavities, too many or too few teeth)						
Gum disease						
Hypertension (high blood pressure)						
Heart murmurs						
Mitral valve prolapse						
Heart attack (coronary)						
Hemophilia (free bleeder)						
Stroke						
Congestive Heart Defect						
Anemia						
Cooley's anemia (Thalassemia)						
Heart Surgery (date of surgery)						
Blood disorder						
Alzheimer's Disease						
Eczema, acne or other skin condition						
Hives						
Atherosclerosis						
Mononucleosis						
Hepatitis (specify type)						
Jaundice or yellow skin						
Cirrhosis						
Other liver problems						

Medical Condition	You	Your mother	Your father	Your brother/s or sister/s	Your children	More Information
Atrial Fibrillation						
Irregular/abnormal heart beat						
Any other heart or circulatory problems (be specific)						
Asthma (medications prescribed)						
Chronic Bronchitis						
Sudden Infant Death Syndrome (SIDS)						
Pneumonia						
Reactive airway disease						
Angina						
Other respiratory disorders						
Ulcers (be specific)						
Gall bladder problem						
High Cholesterol						
Obesity						
Anorexia/Bulimia						
Suicide or attempted suicide						
Other Digestive Disorders (be specific)						
Bladder Problems						
Kidney failure/transplant or problems						
Kidney stones						

Medical Condition	You	Your mother	Your father	Your brother/s or sister/s	Your children	More Information
Eczema or other skin conditions						
Alcoholism or heavy drinking						
Drug usage (list specific drugs)						
Other mental or behavioral disorders (be specific)						
Multiple sclerosis						
Lou Gehrig's disease						
Seizures or convulsions (medications prescribed)						
Huntington's disease						
Parkinson's Disease						
Epilepsy						
Tourette's syndrome						
Crohn's Disease						
Lyme Disease						
Migraine headaches						
Other nervous system disorders (be specific)						
Arthritis						
Hodgkin's disease						
Cysts, lumps, or growths						
Endometriosis						
Menstrual problems						
Problem pregnancies						
Emphysema						

Medical Condition	You	Your mother	Your father	Your brother/s or sister/s	Your children	More Information
Tay-Sachs Disease						
Birthmarks (unusual size or shape)						
Pyloric stenosis (projectile vomiting)						
Neurofibromatosis						
Arthritis						
Lupus						
Rheumatic Fever						
Speech problems						
Learning disability (specify diagnosis)						
Dyslexia						
Autism						
Hyperactivity ADHD/ADD						
Chromosome abnormality						
Back problems (pinched nerve, slipped disc)						
Scoliosis (curvature of spine) or hunchback						
Harelip (Cleft lip) or Cleft palate						
Cerebral Palsy						
Muscular dystrophy						

Have you ever gone to a psychologist, psychiatrist, clinical social worker, mental health or behavioral health therapist for any emotional or psychological or behavioral problems you may have had? Yes ☐ No ☐

If yes: Date(s) and reasons for treatment:

_____
_____

Name and location of therapist and/or agency that provided treatment:

_____
_____
_____

Indicate medications prescribed during treatment

_____
_____
_____
_____

Reason for discontinuance if no longer in treatment

_____
_____
_____
_____

Please list any other medical issues or information about you, your family or the birth father or his family that were not covered in the information above:

_____
_____
_____
_____
_____
_____

Would you be willing to be contacted in the future if a health problem arises for the child which requires either additional health history, transfusion or an organ transplant? Yes ☐ No ☐
Comments:

_____
_____

The above information is true and accurate to the best of my knowledge

_____
Signature

_____
Print Name

_____
Date