

## “SAFELY SURRENDERED BABY” Medical Questionnaire

THANK YOU FOR CHOOSING TO GIVE THIS BABY A SAFE AND SECURE FUTURE

**NOTICE:** THE BABY YOU HAVE BROUGHT IN TODAY MAY HAVE SERIOUS MEDICAL NEEDS IN THE FUTURE THAT WE DON'T KNOW ABOUT TODAY. SOME ILLNESSES, INCLUDING CANCER, ARE BEST TREATED WHEN WE KNOW ABOUT FAMILY MEDICAL HISTORIES. IN ADDITION, SOMETIMES RELATIVES ARE NEEDED FOR LIFE-SAVING TREATMENTS. TO MAKE SURE THIS BABY WILL HAVE A HEALTHY FUTURE, YOUR ASSISTANCE IN COMPLETING THIS QUESTIONNAIRE FULLY IS ESSENTIAL. THANK YOU.

Please remember that these questions will allow us to provide the best supportive care possible to the baby. If you need help answering any of the questions, please ask. If you are uncomfortable answering any of the questions, skip them and answer the rest. Any information you provide will benefit the baby.

**ALL INFORMATION IS CONFIDENTIAL AND WILL BE USED ONLY TO HELP CARE FOR THE BABY.**

1. What were the date, time and place of the baby's birth?  
Date: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m. Place: \_\_\_\_\_
2. Was the baby born early (premature)? \_\_\_\_\_ Late? \_\_\_\_\_ Unknown Due Date? \_\_\_\_\_
3. Did the baby have any trouble starting to breathe?  Yes  No
4. Has the baby been breast fed?  Yes  No  
If yes, how long? \_\_\_\_\_ When was the baby last fed? \_\_\_\_\_  a.m.  p.m.
5. Has the baby been fed formula?  Yes  No  
If yes, how long? \_\_\_\_\_ When was the baby last fed? \_\_\_\_\_  a.m.  p.m.
6. Did the birth mother see a doctor during pregnancy?  Yes  No  
If yes, when did she first see the doctor? \_\_\_\_\_  
How many times did she see the doctor during pregnancy? \_\_\_\_\_
7. Was the birth attended by a physician, midwife, nurse or other health care professional?  Yes  No
8. Has a doctor seen the baby since birth?  Yes  No  
If yes, when? \_\_\_\_\_
9. Did the birth mother smoke cigarettes during the pregnancy?  Yes  No  
If yes, how often? \_\_\_\_\_
10. Did the birth mother drink alcohol during the pregnancy?  Yes  No  
If yes, how often? \_\_\_\_\_
11. Did the birth mother take over the counter or prescription medication during the pregnancy?  Yes  No  
If yes, what type? \_\_\_\_\_ How often? \_\_\_\_\_
12. Did the birth mother take recreational or "street" drugs during the pregnancy?  Yes  No  
If yes, what type? \_\_\_\_\_ How often? \_\_\_\_\_
13. Has the birth mother been pregnant before?  Yes  No  
If yes, how many times? \_\_\_\_\_  
  
Were there any problems with any of those pregnancies or births?  Yes  No  
Please explain \_\_\_\_\_
14. Race/ethnicity of the baby's parents: Mother \_\_\_\_\_ Father \_\_\_\_\_
15. Does the baby have any Native American ancestry?  Unknown  Yes  No  
If yes, what is the name of the tribe? \_\_\_\_\_ From what state? \_\_\_\_\_

**Please tell us if the birth mother, birth father, or any of their relatives  
had or now have any of the medical conditions listed below.**

TYPE OF ILLNESS	RELATIONSHIP TO THE CHILD (Mother, Father, Grandparent, Aunt, Uncle) Please state if relative is mother's or father's	AGE ILLNESS BEGAN
<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Sexually Transmitted Disease What kind? _____	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Cancer What kind? _____	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Mental Illness What kind? _____	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Kidney Problems What kind? _____	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Hearing, vision, or speech problems What kind? _____	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Learning delay/special education	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Allergies What kind? _____	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Arthritis What kind? _____	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	
<input type="checkbox"/> Other What kind? _____	<input type="checkbox"/> Mother's <input type="checkbox"/> Father's	

Please provide any additional information that might help us provide the baby with the best health care now or in the future. (You may use an additional page)