SECTION II – NON IDENTIFYING INFORMATION ABOUT BIRTHMOTHER

This information will be given to the adopting parents and will be available to your child. Please answer all questions as completely as possible. J.C (Initial)

PART I – CHARACTERISTICS OF BIRHTMOTHER AT TIME OF ADOPTEE'S BIRTH

A. GENERAL INFORMATION AND PHYSICAL DESCRIPTION:

HEIGHT	USUAL WEIGHT	EYE COLOR	SKIN COLOR	NATURAL HAIR COLOR	NATURAL HAIR TEXTURE (CHECK ALL THAT APPLY)
4'9	85 lbs.	Brown	light brown	brown	☐ FINE ☐ MEDIUM ☐ COARSE ☐ STRAIGHT ☒ WAVY ☐ CURLY ☐ BALDING

BIRTHDATE (YEAR ONLY)	BIRTHPLACE (STATE ONLY)	BLOOD TYPE	RH FACTOR	BODY TYPE	ARE YOU RIGHT HANDED ☐
2000	AZ			☒ SMALL BONED ☐ MEDIUM BONED ☐ LARGE BONED	LEFT HANDED ☒

Race/Ethnic Group

☐ White ☒ Hispanic ☐ Filipino ☐ Black ☐ Asian or Pacific Islander

☐ American Indian or Alaskan Native ☐ Other (Specify) _____

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

SPECIFIC NATIONALITY DESCENT (EXAMPLE: IRISH, FRENCH, GERMAN, CANTONESE, MEXICAN, NIGERIAN)

B. EDUCATION:

LAST GRADE COMPLETED	PRESENTLY IN SCHOOL	USUAL GRADES IN SCHOOL	OTHER TRAINING
High School	☒ YES ☐ NO	Excellent grades	

EXTRA CURRICULAR ACTIVITIES

SUBJECTS INTERESTED IN

Math, History

C. OCCUPATION:

PRESENT OCCUPATION	HOW LONG?	USUAL OCCUPATION
N/A		

WHAT ARE YOUR OCCUPATIONAL GOALS? (EXAMPLE: TO BE A TEACHER, WELDER, SALES CLERK)

Dental Hyg.

D. PERSONALITY:

DESCRIBE YOUR PERSONALITY IN TERMS OF YOUR USUAL BEHAVIOR, ATTITUDES, MOODS, ACITIVITIES YOU USUALLY PARTICIPATE IN, TYPES OF PEOPLE YOU ENJOY BEING WITH, ETC.

Happy, energetic. Love Hiking & traveling.

DESCRIBE TALENTS, HOBBIES AND GOALS IN LIFE.

Want to continue studies to be in Dental field

DESCRIBE HOW YOU WERE AS A CHILD

happy, imaginative.

E. ADOPTION QUESTIONS:

Religion:

What Religion do you practice: N/A

ARE YOU WILLING TO HAVE YOUR CHILD REARED IN THE RELIGIOUS FAITH OF THE ADOPTING PARENTS, IF DIFFERENT FROM YOUR OWN? ☒ YES ☐ NO

IF NO, WHAT RELIGIOUS FAITH DO YOU WISH YOUR CHILD TO BE REARED?

WHY DID YOU PLACE THIS CHILD FOR ADOPTION? (PLEASE RESPOND AS THOROUGHLY AS YOU CAN. THIS IS THE QUESTION ADULT ADOPTEES MOST OFTEN ASK ADOPTION AGENCIES.)

IF YOUR CHILD WAS NOT PLACED FOR ADOPTION AT BIRTH, GIVE INFORMATION ON THE CHILD'S CARE, HEALTH AND DEVELOOPMENT BEFORE PLACEMENT.

HOW DO YOU FEEL ABOUT BEING CONTACTED BY THE ADOPTEE WHEN HE OR SHE REACHES ADULTHOOD?

Prefer not to be contacted.

F. BIRTHMOTHER'S MENSTRUAL HISTORY AND PREGNANCY HISTORY OF CHILD:

1. MENSTRUAL HISTORY

HOW OLD WERE YOU WHEN YOU BEGAN TO MENSTRUATE?	WHAT IS THE USUAL LENGTH OF YOUR PERIOD?	ARE YOU REGULAR?	NO. OF DAYS IN CYCLE
11	4 days	☒ YES ☐ NO	28 days

DO YOU HAVE PROBLEMS WITH YOUR PERIODS? ☐ YES ☒ NO ☐ IF YES, EXPLAIN

WERE YOU A "DES" BABY? ☐ YES ☒ NO ☐ UNKNOWN

2. THIS PREGNANCY

NAME AND ADDRESS OF OBSTETRICIAN WHO PROVIDED YOU WITH PRENATAL CARE:

NAME OF OBSTETRICIAN	ADDRESS (STREET)	CITY,	STATE	ZIP CODE
Martin Arellano	521 W. Thomas Rd.	Phoenix	AZ	85013

WHEN DID PRENATAL CARE BEGIN?	WHAT WAS YOUR AGE WHEN YOU BECAME PREGNANT?	NUMBER OF WEEKS THIS PREGNANCY?	TYPE OF BIRTH
Mid Jan.	21	30 weeks	☒ SINGLE ☐ MULTIPLE IF MULTIPLE, HOW MANY?

COMPLICATIONS DURING THIS PREGNANCY? ☐ YES ☒ NO ☐ IF YES, EXPLAIN

HAVE YOU GIVEN BIRTH TO ANY OTHER CHILDREN? ☒ YES ☐ NO ☐ IF YES HOW MANY? 1

3. CONDITIONS DURING THIS PREGNANCY

GERMAN MEASLES INFECTIONS	☐ YES	☒ NO	☐ HERPES	☐ GONORRHEA	☐ SYPHILIS	☐ CHLAMYDIA	☐ GENITAL WARTS	VIRUS (E.G., FLU)	☐ YES	☒ NO	
	☐ YES	☒ NO						ACCIDENTS	☐ YES	☒ NO	

IF YES TO ANY OF THE ABOVE, SPECIFY TYPE OF CONDITION(S), DATE(S) AND TYPE OF TREATMENT

4. DRUGS TAKEN DURING, AND WITHIN ONE YEAR PRIOR, TO THIS JPREGNANCY:

a. Prescription Drugs: [Give name(s)]	TAKEN DURING THIS PREGNANCY (Check √ under appropriate column) YES	NO	TAKEN WITHIN ONE YEAR PRIOR TO PREGNANCY YES	NO	WHEN?	HOW OFTEN?	AMOUNT?
1. Baby Aspirin	X				since March	Daily	1
2.							
3.							
4.							
b. Nonprescription Drugs. Including aspirin, nose drops, etc.							
1. Tylenol		X	X		as needed	as needed	as needed
2.							
3.							
4.							
c. Alcohol and other substances:							
1. Alcohol (wine, beer, etc)		X		X			
2. Amphetamines (uppers)		X		X			
3. Barbiturates (downers)		X		X			
4. Tobacco		X		X			
5. Cocaine		X		X			
6. Crack		X		X			
7. Heroin		X		X			
8. LSD		X		X			
9. PCP		X		X			
10. Marijuana		X	X		Oct. 2020	Once	a bite of edible
11. Other (specify)		X		X			

Have you ever been an IV drug user? ☐ YES ☒ NO

G. PERSONAL HEALTH HISTORY

DESCRIBE YOUR GENERAL HEALTH

Good

WHAT CHILDHOOD DISEASES HAVE YOU HAD?

MEASLES ☐ RUBELLA (3 DAY) ☐ RUBELLA (2 WEEK) ☐ MUMPS ☐ CHICKEN POX ☐ WHOOPING COUGH ☐ HAYFEVER ☐ ROSEOLA ☐ ASTHMA ☐ EAR INFECTIONS ☐ ENCEPHALITIS ☐ MENINGITIS ☐ EAR RHEUMATIC FEVER ☐ HEART MURMUR ☐ SCARLET FEVER ☐ RHEUMATIC FEVER ☐ URINARY/BLADDER INFECTIONS ☐ OTHER (Specify)

ANY MAJOR SURGERY?

☐ YES ☒ NO IF YES, FOR WHAT CONDITIONS/and when?

ARE YOU A: ☐ TWIN ☐ TRIPLET ☐ OTHER MULTIPLE BIIRTH

ARE YOU AN ☐ IDENTICAL OR ☐ FRATERNAL TWIN

H. FAMILY HISTORY

WERE YOU OR ANY MEMBER OF YOUR IMMEDIATE FAMILY ADOPTED?

☐ YES ☒ NO IF YES, PLEASE TELL WHO

	YOUR BIOLOGICAL FATHER	YOUR BIOLOGICAL MOTHER
Current age	38	37
If deceased, age at death	N/A	N/A
Cause of death	N/A	N/A
Height & Weight	HEIGHT 5'6 WEIGHT 150 lb	HEIGHT 5'0 WEIGHT 115 lbs
Hair color and texture	Brown Straight	Brown wavy
Eye color	Brown	Brown
Skin color	Light Brown	Brown
Left or right handed	Right	Right
Outstanding features		
Education Completed	high school	high school
Occupation	landscaping	beauty
Race/Ethnic Group	☐ WHITE ☒ HISPANIC ☐ BLACK ☐ FILIPINO ☐ ASIAN OR PACIFIC ISLANDER ☐ OTHER (SPECIFY ☐ AMERICAN INDIAN OR ALASKAN NATIVE	☐ WHITE ☒ HISPANIC ☐ BLACK ☐ FILIPINO ☐ ASIAN PACIFIC ISLANDER ☐ OTHER (SPECIFY) ☐ AMERICAN INDIAN OR ALASHAN NATIVE
Nationality	Mexican	Mexican
Religion	N/A	N/A
Was this parent aware of your pregnancy?	☒ YES ☐ NO	☒ YES ☐ NO
How many brothers or sisters did she/he have?	1 brother 2 sisters	4 sisters 1 brother
If any of your aunts or uncles have died, give age at death and cause of death.	N/A	N/A

	YOUR FATHER'S PARENTS		YOUR MOTHER'S PARENTS	
	FATHER	MOTHER	FATHER	MOTHER
Age	77 yrs	57 yrs		57 yrs
If deceased, age at death and cause of death	N/A		67 yrs. cancer liver	
Describe physical appearance	N/A		N/A	
Height & Weight	HEIGHT N/A WEIGHT		HEIGHT N/A WEIGHT	
Outstanding Features	Dad has green eyes		N/A	
Education completed	N/A		N/A	
Current of former occupation	landscaping - stay home		construction - stay home	
Was he/she aware of your pregnancy?	☐ YES ☒ NO		☐ YES ☒ NO	

H. FAMILY HISTORY: (continued)

YOUR BROTHERS AND SISTERS

(If you have more than 4 siblings, please use additional paper)

	1	2	3	4
Sex (Male or Female)	Male	Female	Male	Male
Age	22	15	13	9
If deceased, age at death and cause				
Full or half sibling to you?	☐ FULL ☒ HALF	☐ FULL ☒ HALF	☐ FULL ☒ HALF	☐ FULL ☒ HALF
Height & Weight	HEIGHT / WEIGHT	HEIGHT / WEIGHT	HEIGHT / WEIGHT	HEIGHT / WEIGHT
Hair color and texture	Brown	Brown	Brown	Brown
Eye color	Brown	Brown	Brown	Brown
Skin color	Light Brown	Brown	Light Brown	Brown
Hobbies and talents	soccer, music guitar	Cheer	Basketball	gaming
Last grade completed	highschool			
Presently in school?	☐ YES ☐ NO	☒ YES ☐ NO	☒ YES ☐ NO	☒ YES ☐ NO
Occupation				
Aware of Pregnancy?	☐ YES ☒ NO	☒ YES ☐ NO	☐ YES ☒ NO	☒ YES ☐ NO
Marital Status	single	single	single	single
Number of children they have	0	0	0	0
Health of their children	Ø	Ø	Ø	Ø

YOUR OTHER CHILDREN

(If you have more than 4 children, please use additional paper)

	Child #1	Child #2	Child #3	Child #4
Indicate if son or daughter	Son			
Birthday (mo/day/yr) or age	03-25-2020			
Full or half sibling to you?	☒ FULL ☐ HALF	☐ FULL ☐ HALF	☐ FULL ☐ HALF	☐ FULL ☐ HALF
If deceased, age at death				
Cause of death				
Height & Weight	HEIGHT / WEIGHT	HEIGHT / WEIGHT	HEIGHT / WEIGHT	HEIGHT / WEIGHT
Hair color and texture	light Brown			
Eye color	Hazel			
Skin color	light			
Left or right handed				
Grade completed				
Does this child live with you	☒ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Hobbies and talents				
General health				
Major surgery				
Health problems				
Was this child aware of the pregnancy?	Baby ☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

I. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES

Indicate by checking appropriate box if YOU or any RELATIVES (i.e., your parents, sisters, brothers, aunts, uncles, grandparents, other children born to you, etc.) have had or now have the medical conditions listed below. Indicate person's relationship to you. Please complete Comments Section. If a medical condition resulted in death of a family member, indicate this and the person's approximate age at time of death in Comments Sections.

MEDICAL CONDITION	NO	Not Known	YES Self	YES – RELATIVE *(Specify relationship)*	COMMENTS
A CONGENITAL IMPAIRMENTS					
1. Clubfoot or any orthopedic problem (i.e., flat footed, etc.)	X				
2. Harelip (cleft lip or cleft palate)	X				
3. Down's Syndrome	X				
4. Other Chromosome abnormality	X				
5. Hydrocephalus	X				
6. Muscular dystrophy	X				Parts of body involved? Age at onset?
7. Dwarfism	X				
8. Spina bifida	X				
9. Congenital heart defect	X				
10. Sickle Cell Anemia	X				
11. Tay-Sachs disease	X				
B ALLERGIES					To what allergies? What treatment or medication?
1. Eczema or other skin condition	X				
2. Hay fever or other allergy	X				
3. Drug allergy	X				To what drugs?
4. Food allergy	X				To what foods?
C EYE, DENTAL, EAR AND DEVELOPMENTAL DISORDERS					
1. Blindness, glaucoma, color blindness or other visual problems	X				
2. Corrective glasses or contact lenses			X	mom, X sister	At what age were prescription lenses necessary? Self - 9 yrs. Sister - 5 yrs. mom - unknown
Nearsighted ☒ Farsighted ☐			X	mom, sister	
Astigmatism (Inability to focus) ☐	X				
Strabismus (Cross-eyed) ☐	X				
Other (explain) ☐	X				
3. Braces on teeth or other orthodontia work			X		If so, what orthodontic work and for how long? Braces 3 yrs.

I. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (Continued)

MEDICAL CONDITION	NO	Not Known	YES Self	YES – RELATIVE *(Specify relationship)*	COMMENTS
4. Deafness or other ear problems	X				Special education? If "Yes", indicate age at onset.
5. Speech problems	X				
6. Learning disability	X				Any diagnosis? Hospitalization?
7. Retardation: mental or physical	X				
D CIRCULATORY DISORDERS					
1. Hemophilia	X				
2. Sickle cell anemia or trait	X				
3. Hypertension (high blood pressure)	X				Age at onset? What treatment? Hospitalization?
4. Stroke	X				
5. Heart attack (coronary)	X				
6. Arthritis	X				What kind? Age at onset? What part of body?
7. Kidney disease	X				Age at onset? What treatment?
E HORMONAL DISORDERS					Age at onset? What treatment?
1. Diabetes	X				
2. Thyroid disorder	X				
3. Obesity (overweight)	X				
F RESPIRATORY DISORDERS					Any (known) cause? What treatment?
1. Asthma	X				
2. Emphysema	X				Age at onset?
3. Tuberculosis	X				Age at onset? What kind? What part of body?
G MENTAL AND BEHAVIORAL DISORDERS					Age at onset? What treatment? Hospitalization?
1. Diagnosed schizophrenia	X				
2. Diagnosed manic depressive	X				
3. Other mental illness. Describe, using additional page, if necessary	X				
4. Alcoholism or heavy drinking	X				
5. Drug usage	X				Kind, amount, and when taken?

I. HEALTH HISTORY OF YOU, YOUR PARENTS AND OTHER RELATIVES (Continued)

MEDICAL CONDITION	NO	Not Known	YES Self	YES – RELATIVE *(Specify relationship)*	COMMENTS
H LYMPHATIC DISORDERS				Grandpa	What kind? Age of onset? What part of body? Liver, 60's cancer
1. Cancer					
2. Tumors	X				
3. Cystic fibrosis	X				
4. Hodgkin's disease	X				
I NERVOUS SYSTEM DISORDERS					Parts of body involved? Age at onset?
1. Multiple sclerosis	X				
2. Huntington's disease	X				
3. Cerebral palsy	X				
4. Seizures or convulsions	X				Age at onset? What treatment? Frequency?
5. Epilepsy	X				
J INFECTION, HOSPITALIZATION					Diagnosis?
1. Repeated attacks of fever with known infection	X				
2. Repeated severe infection necessitating hospitalization	X				
3. Hospitalization, operation, or injury	X				What for? When?
K OTHER MEDICAL OR HEALTH PROBLEMS	X				