D.R.L. §§112(3)(6)
S.S.L. §373-a

Form 1-D
(Child's Medical History - Agency or Private-Placement)
12/97

FAMILY COURT OF THE STATE OF NEW YORK
COUNTY OF

In the Matter of the Adoption of
A Child whose First Name is

(Docket)(File) No.

Child's Medical History (Agency or Private-Placement)

1. Age and date of birth of child:

2. Has the child had any of the following illnesses or health problems: (Where indicated, specify below or on additional sheet).

___ (AIDS Infection) (HIV positive status)[1]
___ Allergy to foods/other substances
___ Allergy to medications (prescription or over-the-counter)
___ Asthma
___ Chicken Pox
___ Circulatory system disorders (specify):
___ Diabetes
___ Diphtheria
___ German Measles (Rubella)
___ Measles (Rubeola)
___ Hay Fever
___ Heart problems (specify):
___ Hepatitis
___ Kidney disease
___ Malaria
___ Mental/Behavioral disorders (specify):
___ Mumps
___ Parasites in stool
___ Rheumatic Fever
___ Scarlet Fever
___ Sickle Cell Anemia/Trait
___ Tuberculosis
___ Typhoid Fever
___ Urinary tract infection
___ Whooping Cough (Pertussis)
___ Other (specify):
___ Operations/Accidents/Fractures (specify):

3. Immunizations: give dates of the following:

D.P.T/D.T. _____
Polio (oral) _____
Measles _____ Mumps _____ Rubella _____
Hemophilus Influenza B. (H.I.B.) _____
Heptavax/Hepatitis Immune Globulin _____
Influenza (Flu) _____
Pneumonia vaccine _____

[1] Delete inapplicable provision.

Other (specify) _____
Tuberculosis test (most recent/result) _____

4. List Pre-natal History:

___ First trimester bleeding
___ Toxemia (high blood pressure or protein in the urine)
___ Medications (other than vitamins or iron)

___ Diabetes or thyroid problem (specify):

___ Drugs (such as marijuana, heroin, methadone or amphetamines) (specify):

___ Alcohol (occasional)(moderate)(heavy)[2] (specify):

Birth:

Birth weight _____ length _____
Apgar score: 1 min. _____ 5 mins. _____
Date baby was due _____
Date baby was born _____
Complications of delivery:
___ Premature rupture of membranes
___ Caesarian: routine _____ emergency _____
___ Excessive bleeding: abruption _____ placenta previa _____

Newborn:

___ Resuscitation required
___ Yellow jaundice:
lights _____ exchange transfusion _____
___ Infection (specify):
___ Breathing problem (specify):
___ Other (specify):

5. List congenital impairments, including physical defects, if any.

6. State present health or cause of death (give ages), if known, of:

[2]Delete inapplicable provision.

Birth father:
Birth mother:
Siblings: full:
half:

7. If known, indicate whether birth mother had any of the following:

___ Tuberculosis
___ Diabetes
___ Mental or nervous disorder e.g., schizophrenia, depression, manic depressive illness (specify):
___ Thyroid disease
___ Stroke
___ Sickle cell anemia
___ (Aids infection) (HIV positive status)*
___ High blood pressure
___ Bleeding tendency
___ Eye or ear disorder
___ Retardation: mental
___ Physical disability (specify):
___ Circulatory or blood disorders (specify):
___ Obesity
___ Asthma
___ Gastrointestinal disease, (e.g., gall bladder, ulcer, irritable bowel disorder) (specify):
___ Breast cancer
___ Colon cancer
___ Cancer, other (specify):
___ Arthritis or rheumatism
___ Kidney disease (specify):
___ Alcoholism or other substance abuse (specify):
___ Developmental disorder (e.g., learning disability, (attention deficit)(specify):
___ Other (specify):

8. If known, indicate whether birth father had any of the following:

___ Tuberculosis
___ Diabetes
___ Mental or nervous schizophrenia, depression, manic depressive illness (specify):
___ Thyroid disease
___ Stroke
___ Sickle cell anemia
___ Asthma
___ Gastrointestinal disease (e.g., gall bladder, ulcer, irritable bowel disorder) (specify):
___ Colon cancer
___ Cancer, other (specify):

___ (AIDS infection)
(HIV positive status)*

___ Arthritis or rheumatism
___ Kidney disease
(specify):

_____

*Delete inapplicable provision.

___ High blood pressure
___ Bleeding tendency
___ Eye or ear disorders
___ Retardation: mental
___ Physical disability
(specify)
___ Circulatory or blood
disorders (specify):
___ Obesity

___ Alcoholism or other substance
abuse (specify):

___ Developmental disorder
(e.g., learning disability,
attention deficit disorder)
(specify):
___ Other (specify):

Indicate source for information about child's medical history
and the source(s) for information about medical history of birth father and birth mother and whether from direct or indirect source:

Completed by (state official
title, if any): _____

_____
Petitioner

_____
Print or type name

_____
Signature of Attorney, if any

_____
Attorney's Name (Print or Type)

_____
_____
_____
Attorney's Address and Telephone Number