

Family Life Services

P.O. Box 4199
Lynchburg, Virginia 24502

Social and Medical History-Birth Father

Full Name: _____

Current Address: _____

Permanent Address (if different): _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Date of Birth: _____ Place of Birth: _____

Social Security #: _____ Driver's License Number: _____

Age		Race	
Height		Religion	
Weight		Marital Status	
Complexion		Education	
Eye Color		Occupation	
Hair Color		Military Service	

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 N/A

Do you have a passport or visa number? _____

Describe your Personality: _____

Do you have children? Yes _____ No _____ How Many? _____

Child's Name	Date of Birth	Birth Weight	Delivery Type	Duration of Labor	Born Early, on Time, Or Late	Birth Defects	Who is Parenting this Child?

Your Birth History:

Your weight at birth: _____ Your length at birth: _____

Any complications? _____

Health History of Birth Father and Family:

Place an "X" if the listed medical condition exists in your medical history or if you, your grandparents, parents, siblings, or children have/had any of the conditions. If one of your family member'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. Please only include biological family members.

	You	Your Mother	Your Father	Your Siblings	Your Children	Indicate type, area affected, age onset, treatments, etc.
Seasonal Allergies						
Food Allergies						
Drug Allergies						
Other Allergies						
Cancer						
Diabetes						
Brain Tumor						
Intellectual Disability						
Down's Syndrome						
Turner's Syndrome						
Hydrocephalus						
Microcephalus						
Other Developmental Disorders						
Obsessive Compulsive Disorder (OCD)						
Diagnosed Schizophrenia						
Diagnosed Bipolar						
Borderline Personality Disorder						
Serious Depression						
Diagnosed Manic Depressive						
Suicide/Attempted Suicide						

	You	Your Mother	Your Father	Your Siblings	Your Children	Indicate type, area affected, age onset, treatments, etc.
Other Mental Disorders						
Other Behavioral Disorders						
Alcoholism or Heavy Drinking						
Drug Use						
Lymphoma						
Neuro Tube Defect						
Fetal Alcohol Syndrome						
Ambiguous Genitalia						
Osteoporosis						
Colitis						
Apnea Monitor						
Bed Wetting						
Wilson's Disease						
Trisomy						
Gout						
Sickle Cell Anemia or Trait						
Cystic Fibrosis						
Club Foot/Orthopedic Problems						
Cleft Lip/Cleft Palate						
Cerebral Palsy						
Muscular Dystrophy						
Dwarfism						
Spina Bifida						
Congenital Heart Defect						
Tuberculosis						

	You	Your Mother	Your Father	Your Siblings	Your Children	Indicate type, area affected, age onset, treatments, etc.
Nearsighted						
Farsighted						
Astigmatism						
Different color eyes						
Night/Color Blindness						
Glaucoma						
Blindness						
Strabismus (cross eye)						
Cataracts/Other Vision Problems						
Sinus or Nasal Problems						
Ear Infections						
Deafness						
Dental Problems						
Gum Disease						
Speech Problems						
Dyslexia						
Autism						
Hyperactivity ADHD/ADD						
Learning Disability						
Hypertension						
Heart Murmurs						
Mitral Valve Prolapse						
Heart Attack						
Hemophilia						
Stroke						
Congestive Heart Defect						

	You	Your Mother	Your Father	Your Siblings	Your Children	Indicate type, area affected, age onset, treatments, etc.
Anemia						
Heart Surgery						
Blood Disorder						
Alzheimer's Disease						
Eczema/Acne/ Other skin condition						
Hives						
Atherosclerosis						
Mononucleosis						
Jaundice						
Cirrhosis						
Other Liver Problems						
Scoliosis						
Back Problems						
Arthritis						
Lupus						
Rheumatic Fever						
Atrial Fibrillation						
Irregular Heart Beat						
Other Heart Problems						
Asthma						
Chronic Bronchitis						
Sudden Infant Death Syndrome						
Pneumonia						
Reactive Airway Disease						
Angina						
Other Respiratory Problems						

	You	Your Mother	Your Father	Your Siblings	Your Children	Indicate type, area affected, age onset, treatments, etc.
Ulcers						
Gall Bladder Problem						
High Cholesterol						
Obesity						
Anorexia/Bulimia						
Other Digestive Disorders						
Bladder Problems						
Kidney Failure						
Kidney Transplant						
Kidney Stones						
Multiple Sclerosis						
Lou Gehrig's Disease						
Seizures or Convulsions						
Huntington's Disease						
Parkinson's Disease						
Epilepsy						
Tourette's Syndrome						
Crohn's Disease						
Lyme Disease						
Migraine Headaches						
Other Nervous System Disorders						
Arthritis						
Hodgkin's Disease						
Cysts/Lumps/Growths						

	You	Your Mother	Your Father	Your Siblings	Your Children	Indicate type, area affected, age onset, treatments, etc.
Emphysema						
Chromosome Abnormality						
Tay-Sachs Disease						
Birthmarks						
Pyloric Stenosis (projectile vomiting)						
Neurofibromatosis						
Meningitis						
HIV/AIDS						

Please list any hospitalizations you have had including dates and reasons for hospitalization:

Please list any other medical issue within your family that was not covered above: _____

Mental Health History of Birth Father:

Have you ever received a mental health diagnosis? _____

If yes, please describe _____

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

Dates/Reasons: _____

Name and location of therapist/agency: _____

Indicate medications prescribed during treatment: _____

Reason for discontinued treatment: _____

Please list any hospitalizations for psychiatric treatment: _____

Please list any other mental health issue within your family that was not covered above:

Social History of Birth Father's Parents and Siblings:

Please answer to the best of your ability. If you do not know the answer, leave it blank.

If you have additional siblings, please list them on a separate sheet of paper.

	Your Mother	Your Father	Your Brother/Sister#1	Your Brother/Sister #2
Name				
Please Specify Relationship: ie. Biological, Half, Step, Adopted				
Address				
Phone Number				
Age Or Year Of Birth				
Race				
Ethnic Origin				
Height				
Eye Color				
Hair Color				
Religion				
Marital Status				
Military Service				
Education Level				
Occupation				
Interests				

If you have any siblings, are you a twin or triplet? Yes No

If yes, are you identical or fraternal? _____

Social History of Birth Father's Grandparents:

Please answer to the best of your ability. If you do not know the answer, leave it blank.

	Your Mother's Mother	Your Mother's Father	Your Father's Mother	Your Father's Father
Name				
Address				
Phone Number				
Age or Year of Birth				
Race				
Ethnic Origin				
Height				
Eye Color				
Hair Color				
Religion				
Marital Status				
Military Service				
Education Level				
Occupation				
Interests				

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

Birth Father Signature: _____ **Date:** _____

Caseworker Signature: _____ **Date:** _____