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ADOPTION INFORMATION
BACKGROUND/MEDICAL INFORMATION ON BIRTH FATHER

Date: _____

Full Name: _____

Other Name: _____
(Or any other name you have been known by in the past)

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Who do you live with? _____

Relationship: _____

SSN: _____ **DL#** _____

Race: _____ (Specify: Caucasian, African American,
Spanish American, Puerto Rican, Asian
American, Native American, other)

Date of Birth: _____ **Current Age:** _____

Place of Birth: _____ **State:** _____

Pursuant to Florida law, all papers and records pertaining to adoption are confidential and subject to inspection by outside parties only upon Order of the court. However, it is understood that you consent to the disclosure of the non-identifying information contained in this form to prospective adoptive parents.

YOUR GENERAL HEALTH

Height: _____
Eye Color: _____
Complexion: _____
Hair Color: _____

Weight: _____
Blood Type: _____
Build: _____
Naturally Curly Hair? _____

_____ Right Handed? _____ Left Handed?

Do you wear glasses or contact lenses? _____

If so, are you: _____ Near sighted or _____ Far sighted

Other vision problems? _____

Did you wear braces? _____

Do you have dental problems? (frequent cavities, overbite or soft enamel?) _____

If yes, explain _____

YOUR BIOLOGICAL PARENTS

MOTHER

FATHER

First Name: _____ / _____

Age or DOB: _____ / _____

Current Residence (City Only)

_____ / _____

Occupation: _____ / _____

Education: _____ / _____

Height: _____ / _____

Weight: _____ / _____

Hair Color: _____ / _____

Eye Color _____ / _____

General Physical Condition:

_____ / _____

Health Problems:

_____ / _____

Tendency toward baldness:

_____ / _____

If deceased, list cause and date:

_____ / _____

YOUR GRANDPARENTS

	Mother's Mother	Mother's Father	Father's Mother	Father's Father
Is Grandparent Alive?	_____ /	_____ /	_____ /	_____
Current Age or Age when deceased:	_____ /	_____ /	_____ /	_____
Health Problems:	_____ /	_____ /	_____ /	_____
Former Occupation:	_____ /	_____ /	_____ /	_____

YOUR SIBLINGS

Do you have any brothers or sisters? _____ If so, please state:

First Name:	_____ /	_____ /	_____ /	_____
Age or DOB:	_____ /	_____ /	_____ /	_____
Half/Full:	_____ /	_____ /	_____ /	_____
Sex:	_____ /	_____ /	_____ /	_____
Height:	_____ /	_____ /	_____ /	_____
Weight:	_____ /	_____ /	_____ /	_____
Hair Color:	_____ /	_____ /	_____ /	_____
Eye Color:	_____ /	_____ /	_____ /	_____
Health:	_____ /	_____ /	_____ /	_____
Education:	_____ /	_____ /	_____ /	_____
Occupation:	_____ /	_____ /	_____ /	_____
If deceased, list cause, age and date:	_____ / _____ / _____ / _____			

YOUR CHILDREN

Do you have other children? _____ If so, please answer for each:

First Name: _____ / _____ / _____ / _____

Age or DOB: _____ / _____ / _____ / _____

Sex: _____ / _____ / _____ / _____

Full Sibling?: _____ / _____ / _____ / _____

Height @ Birth: _____ / _____ / _____ / _____

Weight @ Birth: _____ / _____ / _____ / _____

Hair Color-Present: _____ / _____ / _____ / _____

Eye Color-Present: _____ / _____ / _____ / _____

Health: _____ / _____ / _____ / _____

Lives With: _____ / _____ / _____ / _____

If deceased, list cause, age and date:

_____ / _____ / _____ / _____

Have you placed other children for adoption? _____

YOUR GENERAL BACKGROUND

Are you or is anyone in your family especially talented in music, art, sports, mechanics, languages, writing, etc.?

What are your hobbies and interests? _____

What is your family's ethnic background? _____

Were your grandparents or great grandparents from another country? _____

Are you a registered member of any American Indian Tribe or Alaskan Village? _____

If so, please indicate tribe or village, it's location and your registration number: _____

EDUCATION:

Are you presently in school? _____

Name of school: _____ Class: _____

If not, please state the last grade you completed: _____

Would you say you were an _____ excellent _____ good
_____ fair _____ poor student?

Did you have special academic interests? _____

Did you have any special sports or other interests? _____

Were there any subjects that caused you problems? _____

Have you ever had learning disabilities? _____

Have you attended or do you plan to attend college? _____

EMPLOYMENT

Present (or Most Recent) Career / Occupation: _____

Salary _____ Length of Employment: _____

Address of Present Employer _____

Telephone No: _____ Work Hours _____

Can you be called at work? _____ Yes _____ No

What are your career hopes and goals? _____

MARITAL STATUS/RELIGION

Married: _____ Separated: _____ Single: _____

Divorced: _____ Widowed: _____ Date/Cause of death: _____

If you are married (even if you are separated), please provide the full name and last known address of your spouse:

If you are divorced or widowed, please provide the following information:

Name of spouse: _____

Date/Place of Marriage: _____

Date/Place of Divorce: _____

Please specify your religion: _____

GENERAL QUESTIONS

Did you consider any plan for your child other than adoption? _____
If yes, what other plans? _____

Who supports your adoption decision? (List family members, friends, etc.)
_____/_____
_____/_____
_____/_____

Who opposes your adoption decision?
_____/_____
_____/_____
_____/_____

What factors influenced your decision to place this child for adoption?

How strong is your commitment to complete an adoption plan? _____

Have you ever been arrested? _____ If so, please list date(s), place(s), charge(s), and
all disposition(s) _____

Have you had military service? _____

Are the following people aware of this pregnancy?

Parents _____ Grandparents _____

Siblings _____ Roommate(s) _____

Are the following people aware of your adoption plan?

Parents _____ Grandparents _____

Siblings _____ Roommate(s) _____

MEDICAL INFORMATION OF BIRTH PARENT

Indicate by checking the appropriate box if you or an immediate family member (i.e., parents, grandparents, brothers, sisters, or children) have had or now have, the medical conditions listed below. Place an "X" if you or your family members have ever had the medical condition listed. Indicate relative's relationship to you.

MEDICAL CONDITION	YOU	YOUR FAMILY Specify Relationship	Explanation of Condition
Club Foot or orthopedic problems			
Hairlip (cleft lip) or cleft palate			
Chromosome Abnormality			
Congenital Heart Defect			
Down's Syndrome			
Hydrocephalus			
Muscular Dystrophy			
Spina Bifida			
Tay Sachs Disease			
Multiple Sclerosis			
Cerebral Palsy			
Seizures, convulsions or Epilepsy			
Anemia			
AIDS			
Blood Disorders			
Cancer / Leukemia			
Tumors			
Cystic Fibrosis			
Huntington's Disease			
Hodgkin's Disease			
Alzheimer's Disease			
Blindness, Glaucoma, or other visual problems			

Indicate cause, treatment, specific medications, parts of body ⁷involved, age of onset of any other explanatory information. When more than one condition or relative is indicated, specify ⁷clearly.

MEDICAL CONDITION	YOU	YOUR FAMILY Specify Relationship	Explanation of Condition
Deafness or other ear problems			
Speech problems			
Learning Disability			
Retardation: Mental or physical			
Hemophilia			
Diabetes			
Thyroid Disorder			
Sickle Cell Anemia or Trait			
Hypertension (high blood or low blood pressure)			
Stroke			
Heart Disease / Attack			
Asthma			
Arthritis			
Lung Disease			
Kidney Disease			
Tuberculosis			
Mental Illness			
Schizophrenia			
Manic Depressive / Bi Polar Disorder			
Alcoholism			
Drug Usage			
Other paralysis or crippling disorder			
Other hormone disorder			
Other cardiovascular problem			
Repeated attacks of fever with no infection			

MEDICAL CONDITION	YOU	YOUR FAMILY Specify Relationship	Explanation of Condition
Eczema or other skin condition			
Breast/Ovarian Cysts			
Bladder Problems			
Venereal Disease			
Herpes			
Colitis			
Obesity			
Baldness			
Gout			
Ulcers			
High Cholesterol			
Birth Defects			
ALLERGIES			
- Hayfever			
- Food			
- Anesthetic			
- Penicillin			
- Antibiotics			
- Sulfa			
- Codeine			
- Aspirin			
- Iodine			
Other:			
Any other Medical Information:			

MEDICATION / DRUGS

Indicate in appropriate space medication / drugs taken during the twelve months prior to this pregnancy.

MEDICATION	YES	NO	YEAR	TYPE, FREQUENCY & AMOUNT
Aspirin				
Antibiotics				
Antihistamines				
Hormones				
Cortisone				
Diet Pills				
Sleeping Pills				
Nerve Pills/Tranquilizers				
Medicine for Cancer				
Heart/Blood Pressure Pills				
Thalidomide				
Medicine for nausea				
Nose drops				
Alcohol				
Amphetamines				
Barbiturates				
Cocaine				
Heroin				
LSD				
Ecstasy				
Special K				
Marijuana				
Cigarettes				
List all other medications:				