HAUSMANN & HICKMAN, P.A.
----------ATTORNEYS AT LAW----------

Michelle M. Hausmann, Esq.
Amy U. Hickman, Esq.

Phone: (561) 732-7030
Fax: (561) 732-7430

2423 Quantum Blvd, Boynton Beach, Florida 33426

ADOPTION INFORMATION
BACKGROUND/MEDICAL INFORMATION ON BIOLOGICAL MOTHER

Date:_____

Full Name:_____

Maiden 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:**_____

Estimated Delivery Date:_____

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: _____ **Weight:** _____
Eye Color: _____ **Blood Type:** _____
Complexion: _____ **Build:** _____
Hair Color: _____ **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) _____

PREGNANCY HISTORY

Is this your first pregnancy? _____

If not, how many prior pregnancies? _____

Please describe what occurred with these pregnancies (Indicate #)

Birth: Vaginal _____ Miscarriage _____

C-Section _____ Abortion _____

Were there any problems with prior births? _____

If so, describe (i.e., full term, overdue, premature, or other): _____

_____

_____

MEDICAL INFORMATION INVOLVING THIS PREGNANCY

Are you seeing a doctor? _____

Date of first visit: _____

Doctor's Name: _____

Address: _____

Telephone Number: _____

Does your doctor know you are considering adoption? _____

Month prenatal care began: _____

Have you taken any medication during this pregnancy? _____

If so, what medication and at what stage? _____

_____

Have you consumed any alcohol during this pregnancy? _____

Have you been involved in an accident during this pregnancy? _____

If so, explain: _____

Have there been any physical problems during this pregnancy? _____

Complications during pregnancy? _____

If so, explain: _____

Ws there any sexual or physical abuse during this pregnancy? _____

If so, explain: _____

X-ray, Electrocardiogram, or radiation exposure during pregnancy? _____

If so, explain: _____

INSURANCE / MEDICAID / CHAMPUS COVERAGE

Do you have Medicaid or other health insurance coverage? _____

Medicaid / Champus Number: _____

Date Benefits began: _____

If health insurance, please state:

Company Name: _____

Phone Number: _____

Policy Number: _____

RELATIONSHIP BETWEEN BIRTH PARENTS

Name of your child's father: _____

His Home address: _____

Describe your relationship with the birth father: _____

_____

Who does he live with? _____

Is he currently employed? _____ If yes, where? _____

Is he the father of your other child(ren)? _____

Is he aware of this pregnancy? _____

Does he know of your plans to place the child for adoption? _____

Does he agree with your plans? _____

Will he sign surrender papers? _____

Has he lived with you before or during this pregnancy? _____

If so, when? _____

Has he provided any financial support during this pregnancy? _____

How much? _____

When? _____

Has he ever filed a petition to be declared the father of this child or otherwise been identified as the father of the child in any court? _____

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 FAMLY 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 involved, age of onset of any other explanatory information. When more than one condition or relative is indicated, specify clearly.

MEDICAL CONDITION	YOU	YOUR FAMLY 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 FAMLY 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 pregnancy involving this child and medication / drugs taken during the three years prior to this pregnancy.

MEDICATION	YES	NO	MONTHS OF PREGNANCY	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:					

AUTHORIZATION TO DISCLOSE SOCIAL/MEDICAL INFORMATION

Name: _____ Soc. Sec. Number: _____

Date of Birth: _____ Health Rec. _____

1. I authorize the use or disclosure of the above named individual's health information as described below.

2. The following individual or organization is authorized to make the disclosure:

   _____
   _____
   _____
   _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

   ☐ laboratory results from (date) _____ to (date)_____
   ☐ x-ray and imaging reports from (date) _____ to (date)_____
   ☐ consultation reports from (doctors' names)_____
   X entire medical record for present pregnancy

4. I understand that the information in my health record may include information relating to social history/intake; sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

   HAUSMANN & HICKMAN, P.A.
   2423 Quantum Blvd.
   Boynton Beach, Florida 33426
   (561) 732-7030

   for the purpose of: an adoption placement.

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to **Hausmann & Hickman, P.A.** I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the

revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in one year from the date of execution.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information
contains the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Hausmann & Hickman, P.A. or an independent attorney.

_____ _____

Patient Date