Iowa Department of Public Health
Bureau of Health Statistics
321 E. 12th St, Lucas State Office Building
Des Moines IA 50319

Medical History Form

ORIGINAL BIRTH CERTIFICATE INFORMATION

This form may be filed with the Bureau of Health Statistics pursuant to Iowa Code section 144.24A. Please provide complete and accurate information. While the Department will diligently search its files for an adoption record that matches your request, it does not warrant, promise or guarantee that it will be able to locate an adoption record that matches the information you provide in your request.

The birth of the child must have occurred in IOWA for this form to be filed.

CHILD'S INFORMATION ON ORIGINAL BIRTH CERTIFICTE PRIOR TO ADOPTION

Child's FIRST Name on Child's Original Birth Certificate:

Child's MIDDLE Name on Child's Original Birth Certificate:

Child's LAST Name on Child's Original Birth Certificate:

Suffix:

Child's Date of Birth ☐ Actual ☐ Estimate

Sex ☐ Male ☐ Female

County of Birth

City of Birth

MOTHER/PARENT INFORMATION ON ORIGINAL BIRTH CERTIFICTE PRIOR TO ADOPTION

Mother's FIRST Name on Child's Original Birth Certificate:

Mother's MIDDLE Name on Child's Original Birth Certificate:

Mother's LAST Name on Child's Birth Certificate:

Mother's MAIDEN Name on Child's Original Birth Certificate:

Mother's Date of Birth

FATHER/PARENT INFORMATION ON ORIGINAL BIRTH CERTIFICTE PRIOR TO ADOPTION

Father's FIRST Name on Child's Original Birth Certificate:

Father's MIDDLE Name on Child's Original Birth Certificate:

Father's LAST Name on Child's Original Birth Certificate:

Father's MAIDEN Name on Child's Original Birth Certificate:

Father's Date of Birth

Please Review and Choose ONE Option

☐ I am not aware of any medical history of any significance.

☐ I prefer not to provide any medical information at this time.

☐ I wish to provide the following medical information included on the attached form.

☐ I wish to provide the following medical information included in the attached form. However, I request that my personally identifiable information be redacted from the medical information form prior to its release under Iowa Code section 144.24A.

By signing, I certify that I am the birth parent of the adoptee and that to the best of my knowledge, the information I am supplying is correct and accurate. I understand that if I falsely represent that I am the birth parent of the adoptee on this form or willingly provide false information, then I may be subject to penalties pursuant to Iowa Code section 144.52 and 144.53.

Signature of Birth Parent Completing This Form

Created 05/2021

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Medical History Form

BIRTH PARENT COMPLETING FORM DEMOGRAPHIC INFORMATION

Person completing this form: ☐ Birth Mother ☐ Birth Father Date form completed:

Your Current Age:
Blood Type:
Eye Color:
Primary Language:
Hair Color:
Nationality:
Height (inches):
Race:
Weight (lbs):
Ethnic Background:
Highest Level of Education:
Religion:
Skin Color:
Parent's Place of Birth Country:
State:
City/Territory:

BIOLOGICAL INFORMATION ABOUT DECEASED FAMILY MEMBERS

List your family members who have passed away, age at death, and cause of death.

Relationship*:	Age at Death:	Cause of Death:
Relationship*:	Age at Death:	Cause of Death:
Relationship*:	Age at Death:	Cause of Death:
Relationship*:	Age at Death:	Cause of Death:
Relationship*:	Age at Death:	Cause of Death:
Relationship*:	Age at Death:	Cause of Death:
Relationship*:	Age at Death:	Cause of Death:
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Relationship*:	Age at Death:	Cause of Death:
Relationship*:	Age at Death:	Cause of Death:
Relationship*:	Age at Death:	Cause of Death:

* Relationship Choices

Mother Father Maternal Grandmother Paternal Grandmother
Son Daughter Maternal Grandfather Paternal Grandfather
Other Biological Parent Sister Brother Aunt Uncle

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Medical History Form

BIRTH PARENT COMPLETING FORM MEDICAL HISTORY INFORMATION

For each of the medical conditions listed below, please check the appropriate column indicating whether you or any of your blood relatives (mother, father, sisters, brothers, grandparents, aunts, uncles) or any other of your children have the condition(s) listed. Comments should include information on age of onset or diagnosis, treatments received or hospitalizations for conditions, etc.

CARDIOVASCULAR (HEART AND BLOOD VESSELS)

Medical Condition	Response		Comments
Congenital Heart Defect	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Congestive Heart Failure	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Atherosclerosis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Hypertension (High Blood Pressure)	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Stroke	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Heart Attack	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Heart Rhythm Abnormality	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Other Cardiovascular Issues	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

NERVOUS SYSTEM (BRAIN AND NERVES) DISORDERS

Medical Condition	Response		Comments
Cerebral Palsy	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Seizures, Convulsions or Epilepsy	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Alzheimer's Disease	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Parkinson's Disease	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Huntington's Disease	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Multiple Sclerosis, Paralysis or Other Crippling Disorder	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

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Des Moines IA 50319

Medical History Form

NERVOUS SYSTEM (BRAIN AND NERVES) DISORDERS *CONTINUED*

Medical Condition	Response		Comments
Hydrocephalus	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Spina Bifida	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Amyotrophic Lateral Sclerosis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Tay-Sachs Disease	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

LUNGS

Medical Condition	Response		Comments
Chronic Bronchitis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Emphysema	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Asthma	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Tuberculosis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Allergies (Including Food or Drug Allergies)	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
COPD	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Cystic Fibrosis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

MUSCULAR / SKELETON

Medical Condition	Response		Comments
Scoliosis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Club Foot	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Osteoarthritis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

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Medical History Form

MUSCULAR / SKELETON *CONTINUED*

Medical Condition	Response		Comments
Rheumatoid Arthritis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Muscular Dystrophy	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Lupus	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Cleft Lip or Palate	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

BLOOD DISORDER

Medical Condition	Response		Comments
Sickle Cell Anemia	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Hemophilia	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Leukemia (Acute or Chronic)	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Factor V Leiden	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

GASTROINTESTINAL (STOMACH / INTESTINES)

Medical Condition	Response		Comments
Ulcers	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Inflammatory Bowel Disease	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Diverticulosis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Crohn's Disease	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Irritable Bowel Syndrome	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

ENDOCRINE (GLANDS) DISORDERS

Medical Condition	Response		Comments
Thyroid Disorder (Hyper/Hypo)	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

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IOWA Department of PUBLIC HEALTH
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Medical History Form

ENDOCRINE (GLANDS) DISORDERS *CONTINUED*

Medical Condition	Response		Comments
Diabetes (Adult/Juvenile)	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Other Hormonal Disorder	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

RENAL (KIDNEYS) DISORDERS

Medical Condition	Response		Comments
Chronic Kidney Disease	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Kidney Failure	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Liver Disorders	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Hepatitis - Specify Type	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Cirrhosis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

REPRODUCTIVE ISSUES

Medical Condition	Response		Comments
Fertility Issues	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
History of Miscarriage	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Endometriosis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

EYE AND EAR DISORDERS

Medical Condition	Response		Comments
Blindness, Glaucoma, or Other Visual Problems	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Deafness or Other Ear Problems	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Speech Problems	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

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Medical History Form

CANCER

Medical Condition	Response		Comments
Cancer (Specify type i.e. Breast, Ovarian, Cervical, Prostate, etc.)	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Tumors	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Cystic Fibrosis	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

SKIN DISORDERS

Medical Condition	Response		Comments
Eczema or Other Skin Conditions	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

DEVELOPMENTAL

Medical Condition	Response		Comments
Learning Disability	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Mental or Physical Development Deficiencies	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Autism Spectrum	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

PSYCHOSOCIAL

Medical Condition	Response		Comments
Chronic Depression	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Alcohol Use	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Prescription Drug Use	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Illegal Drug Use	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Tobacco Use	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Anorexia	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

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Medical History Form

PSYCHOSOCIAL *CONTINUED*

Medical Condition	Response		Comments
Bulimia	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Bipolar Disorder	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	
Schizophrenia	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

OTHER MEDICAL CONDITIONS

Medical Condition	Response		Comments
Any Other Known Conditions Not Listed	☐ No	☐ Yes (Self)	
	☐ Not Known	☐ Yes (Relative)	

Birth Parents Genetically Related to Each Other ☐ Yes ☐ No

Please provide any additional information related to Medical / Social / Cultural History section: