

# Biological Father's Social History

(please print using blue or black ink)

Today's Date:	
Full Name (First, Middle, Last & Maiden)	
Permanent Address (No PO Boxes)	
City	
State	
County	
Zip	
Home Phone (w/area code)	Can we leave identifying messages? Yes    No
Work Phone (w/area code)	Can we contact you at work? Yes    No
Social Security Number	
Driver's License or ID (State and Number)	
Place of Birth (City, State, County)	
Birth Date	
Your Race/Heritage	Caucasian            African-American            Hispanic Native American    Asian    Other _____ (check all that apply)
Nationality	
Occupation	
Marital Status	Single    Married    Separated    Divorced    Other

Previous Marriages	
If Divorced (Date, County & State Finalized)	
U.S. Citizen	Yes No If no, passport/visa # _____
Height	
Weight	
Eye Color	
Skin Color	Fair Olive Tan Dark Other _____
Hair Color/Texture	Blonde Brunette Red Other: _____ Straight Naturally Curly Wavy Texture: _____
Body Structure	
Blood Type	
Religion	
Right/Left Handed	

**CURRENT WORK SCHEDULE**

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
In							
Out							

Name of employer: \_\_\_\_\_

Address of employer: \_\_\_\_\_

What state are you a resident of? \_\_\_\_\_ Month/year residency started? \_\_\_\_\_

How long (months/years) have you lived at your current address? \_\_\_\_\_

Date and time of first contact with us? \_\_\_\_\_

Whom did you first speak with? \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

PREGNANCY AND ADOPTION DECISION

Does anyone in your family know about the pregnancy? Yes No

If yes, do they also know about your adoption plan? Yes No

If yes, are they supportive of your adoption plans? \_\_\_\_\_

Who do you currently live with and are they supportive of your adoption plans? \_\_\_\_\_

Describe your feelings and the reasons why you are placing the child for adoption:

\_\_\_\_\_  
\_\_\_\_\_

Which of you first thought of the idea of adoption? \_\_\_\_\_

How long have you known of the pregnancy? \_\_\_\_\_

Explain the type of home and family you want for your child:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

You are entitled to have an impartial witness (a person who does not have an employment, professional or personal relationship with the adoption entity or the prospective adoptive parents) present when you sign your Consent to Adoption. Please indicate your preference by placing your initials next to your choice below:

\_\_\_\_\_ I would like \_\_\_\_\_ to act as my impartial witness at the time that I sign my Consent to Adoption. He/she can be reached at phone # \_\_\_\_\_ or

\_\_\_\_\_ I choose not to have such a witness.

CHILDREN (other than child to be adopted)

Do you have other children? Yes    No

Do the children currently live with you? If no, explain \_\_\_\_\_

Name and Date of Birth	Gender M/F	School Grade	Height __ft __ in	Weight ___ lbs	Hair Color	Eye Color	Complexion	Please circle
								Full Term, Overdue, Premature
								Full Term, Overdue, Premature
								Full Term, Overdue, Premature

\*\* Use the back of this form if necessary\*\*

CONTACT WITH THE ADOPTIVE FAMILY

Do you want to select the adoptive family? Undecided    Yes    No

Do you want pictures/letters from the family after the adoption? Undecided    Yes    No

If yes, for how long? \_\_\_\_\_

Do you want to meet the adoptive family at the time of placement? Yes    No

Do you authorize us to disclose your name, address and phone number to the adoptive parents? Please initial:    yes \_\_\_\_\_    no \_\_\_\_\_

Use the following lines to include any additional information that you would like the adoptive family and your child to know about you.

---



---



---



---

NATIVE AMERICAN-INDIAN TRIBAL MEMBERSHIP

It is important for us to know if you have are a member, or if you qualify to be a member, of any Native American Indian tribe. Please answer the following questions to the best of your knowledge.

Are you a member of any Native American Indian tribe? Yes No

Do you qualify to be a member of any Native American Indian tribe? Yes No

If yes, please indicate the tribe, location and your registration or identification number: \_\_\_\_\_

---

Are any of your relatives members of any Native American tribes? Yes No

Do any of your relatives qualify to be members of any Native American tribes? Yes No

If yes, please indicate your relative's name and the name and location of the

tribe: \_\_\_\_\_

## Biological Father's Extended Family

(complete to the best of your knowledge)

	Your Mother	Your Father	Your Sister(s)	Your Brother(s)
Name				
Age or Year of Birth				
Race				
Education				
Hobbies/ Interest				
Occupation				
Height				
Weight				
Hair Color				
Eye Color				
Complexion (skin tone)				

\*\*\*Please list any additional information on the back of this form\*\*\*

### Biological Father's Grandparents

(complete to the best of your knowledge)

	Your Mother's Mother	Your Mother's Father	Your Father's Mother	Your Father's Father
Name				
Age or Year of Birth				
Race				
Education				
Hobbies/ Interest				
Occupation				
Height				
Weight				
Hair Color				
Eye Color				
Complexion (skin tone)				

\*\*\*Please list any additional information on the back of this form\*\*\*



If yes, when and how? \_\_\_\_\_

\_\_\_\_\_

Have any relatives had custody of the child? Yes    No

If yes, who and for how long? \_\_\_\_\_

Please list every address where the child has lived from birth to present, the names of all persons who resided at each address and the time period of residence:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all doctors who have treated the child, including any therapist and psychologist. Please provide their phone numbers and addresses.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all schools the child has attended, including the city and state:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Biological Father's

## Medical History

Please complete the following information as accurately as possible. We have wonderful adoptive families willing to accepted children having any medical condition or exposed to any drugs or alcohol. The information is utilized to determine the health of your baby.

## HEALTH HISTORY OF BIOLOGICAL FATHER

Place an "X" if the listed medical condition exists in your medical history or if any relatives or other family members have/had any of the conditions. If one of your relative'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.

<b>Medical Condition</b>	<b>You</b>	<b>Your mother</b>	<b>Your father</b>	<b>Your brother(s) or sister(s)</b>	<b>Your children</b>	<b>Indicate cause, treatment, medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please</b>
HIV/AIDS (medications prescribed)						
Cancer (be specific)						
Diabetes (insulin dependent Yes No )						
Retardation: mental or physical (be specific)						
Down's Syndrome						
Hydrocephalus (water on the brain)						
Other developmental disorders (be specific)						
Diagnosed schizophrenia (medications prescribed)						
Diagnosed manic depressive (medications prescribed)						
Sickle cell anemia or trait						
Cystic fibrosis						
Leukemia						
Club foot or any orthopedic problem						
Harelip (Cleft lip) or Cleft palate						
Cerebral Palsy						
Muscular dystrophy						
Dwarfism						
Spina Bifida						
Congenital heart defect (be specific)						
Tuberculosis						

Medical Condition	You	Your mother	Your father	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, specific medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please
Hay fever						
Food allergy(s)						
Drug allergy(s) (name of drug(s))						
Other allergy(s) (be specific)						
Farsighted						
Nearsighted						
Different color eyes						
Night blindness						
Glaucoma						
Blindness (cause of blindness)						
Other visual problems (be specific)						
Sinus or nasal problems						
Ear infections						
Deafness (cause of deafness)						
Other ear problems (be specific)						
Teeth problems						
Gum disease						
Hypertension (high blood pressure)						
Heart murmurs						
Heart attack (coronary)						
Hemophilia (free bleeder)						
Stroke						
Anemia						
Heart Surgery (date of surgery)						

Medical Condition	You	Your mother	Your father	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, specific medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please
Any other heart or circulatory problems (be specific)						
Asthma (medications prescribed)						
Chronic Bronchitis						
Sudden Infant Death Syndrome (SIDS)						
Frequent pneumonia						
Other respiratory disorders						
Ulcers (be specific)						
Colitis						
Gall bladder problem						
High Cholesterol						
Obesity						
Anorexia/Bulimia						
Colon Cancer						
Other Digestive Disorders (be specific)						
Bladder Problems						
Kidney problems						
Speech problems						
Learning disability (specific diagnosis)						
Eczema or other skin conditions						
Alcoholism or heavy drinking						
Drug abuse (list specific drugs)						
Other mental or behavioral disorders (be specific)						
Multiple sclerosis						

Medical Condition	You	Your mother	Your father	Your brother(s) or sister(s)	Your children	Indicate cause, treatment, specific medications, parts of body involved, age onset or other explanations. When more than one condition or family member is involved please
Lou Gehrig's disease						
Seizures or convulsions (medications prescribed)						
Huntington's disease						
Epilepsy						
Migraine headaches						
Other nervous system disorders (be specific)						
Arthritis						
Hodgkin's disease						
Cysts, lumps, or growths						
Tumors						
Endometriosis	n/a		n/a			
Menstrual problems	n/a		n/a			
Problem pregnancies	n/a		n/a			
Other Medical Conditions (be specific)						
Other						
Other						
Other						

### CONFIDENTIAL DRUG/ALCOHOL USAGE

Please be very specific as to any drugs or alcohol used during your pregnancy, including the number of times and the dates of usage. This information is very important for the prediction of your child's health. This information will be passed along to the adoptive family and to the child's pediatrician. Place an 'X' in the applicable box.

DRUG & ALCOHOL USAGE	Used how long	Frequency and amount
Cigarettes		
Alcohol		
Marijuana		
Cocaine		
Methamphetamines		
Heroin		
Ecstasy		
Methadone		
LSD		
Stimulants (Caffeine included)		
Depressants		
Diet Pills		
Tranquilizers		
Anti-Convulsants		
Other (be specific)		
Other (be specific)		

Please list any other medical issues that were not covered in the information above:

---

---

Please list any additional comments, concerns or questions you may have:

---

---

---

I represent that the information contained in the Biological Father's Social and Medical History is true and accurate. I acknowledge that the adoptive family and other parties will rely on this information in making a determination to proceed with the anticipated adoption and the Court will rely on this information during the adoption related proceedings. I hereby waive any claim of privilege and agree that the information contained on this form and other information about me may be given to the adoptive parents, their agency, their attorney, and other state officials, including law enforcement authorities, through all communication medium.

I further understand that I am entering into a program that places children for adoption and any false statements may be viewed as perjury and in violation of penal laws of my state and may subject me to criminal and/or civil penalties under the law. I also understand that working simultaneously with more than one attorney, agency or adoptive couple may subject me to criminal and/or civil penalties under the law.

In my written and verbal communications in connection with the adoption plan, I have not provided any false or misleading information of any kind including information concerning myself or the background or medical history of my family.

I hereby authorize the Adoption Entity to make inquiry about the truthfulness of the statements made in this document and the circumstances of this placement with other medical, legal and adoption professionals.

Please sign and date on the line below.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date