Voluntary Medical History Form

Dear Birthmother:

Thank you for bringing your baby to a Safe Haven. You have taken the first step in assuring that your newborn will be safe and well cared for. We know this has been a difficult decision and want to assure you that we will do everything we can to give your newborn the best possible care.

We are asking you to help your baby by providing some information voluntarily that may be important in his/her future. This information will be used only for this purpose. It will not be used to identify you or find you. You may not know all of the answers, but please provide as much information as you know.

What is the baby’s birth date? _______________  Was the infant premature? Yes  No

Were there any problems with your pregnancy or delivery? Yes  No
If yes, what were they? __________________________________________________________________
_____________________________________________________________________________________

Where was the baby born? (city/state) ______________________________________________________

Where is the Safe Haven location? (hospital, fire station, police station, EMS facility, other) ___________
_____________________________________________________________________________________

During the pregnancy did you use any of the following:

Cigarettes: How much and at what point in the pregnancy? ___________________________________

Alcohol: How much and at what point in the pregnancy? _____________________________________

Drugs/Medications: Which and at what point in the pregnancy?________________________________

Did you receive any prenatal care? Yes  No
If so, please describe: ___________________________________________________________________

Does your baby have any other siblings? Yes  No
If so, please describe (age, relationship, etc.) ________________________________________________
_____________________________________________________________________________________
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<table>
<thead>
<tr>
<th>Medical Conditions</th>
<th>Medical Conditions</th>
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<tbody>
<tr>
<td>Diabetes</td>
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<td>Down Syndrome</td>
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<td>Asthma</td>
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<td>Allergies</td>
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<td>Seizures</td>
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<td>Cancer</td>
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<td>Heart Disease</td>
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<td>High Blood Pressure</td>
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<td>Muscular Dystrophy</td>
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<td>Mental Illness</td>
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<td>Depression</td>
<td>Depression</td>
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<td>Other</td>
<td>Other</td>
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</table>

**What is your:**
- Age
- Race
- Native American Indian Yes / No
- (Tribal Name)
- Religion
- Approx. Height/Weight
- Eye/Hair Color

**What is the infant’s father’s:**
- Age
- Race
- Native American Indian Yes / No
- (Tribal Name)
- Religion
- Approx. Height/Weight
- Eye/Hair Color