

Non-Identifying Health, Genetic and Social History

This form is required when a child born in Utah is adopted in Utah. Utah Code 78b-6-143.

Date : _____

Adoptions by a step-parent whose spouse is the adoptee's birth parent do not require this form.

AGENCY OR INDIVIDUAL MAKING THE PLACEMENT

1. Individual, Attorney or Agency: _____

1a. Name of person to contact for further information: _____

2. Mailing Address: _____

3. Email Address: _____ 4. Phone: _____

5. Finalized in City/County: _____ 6. Date Finalized: _____

ADOPTEE INFORMATION

7. Name(s): _____

8. Date of Birth: _____ 9. City and County of Birth: _____

10. Birth Mother's city and county of residence at time of child's birth: _____

IF UNABLE TO OBTAIN INFO

The agency responsible for the placement of this child was unable to obtain any additional non-identifying health, genetic, and social information relating to the child because: (check all that apply)

- The child's birth mother failed / refused to provide any information
- The child's birth father failed / refused to provide any information
- The identity of the child's mother is unknown
- The identity of the child's father is unknown
- Other. Please explain: _____

You may turn in page 1
alone if unable to
obtain further info.

Signature of Agency representative: _____

BIRTH MOTHER INFORMATION - facts at the time of the adoptee's birth

11. During the pregnancy were you diagnosed as: Anemic Diabetic Gestational Diabetic

Hypertension Toxemia/Eclampsia

12. Did you have X-rays during this pregnancy? Yes No If Yes, what procedure/type? _____

13. Weight gain during this pregnancy _____ lbs.

14. Delivery history: Weeks gestation _____ Length of Labor _____ hours
APGARS (1/5) _____ Birth weight _____ lbs. _____ oz.

15. This birth: single, twin, triplet (specify:) _____ 16. If not a single birth, born 1st, 2nd, 3rd? _____

17. Month pregnancy prenatal care began: _____ 18. Number of prenatal Visits: _____

19. Describe any prenatal complications: _____

20. Previous live births now living _____ 21. Previous live births now dead _____

22. Other pregnancies - Number of Miscarriage or induced terminations: _____

23. Type of Delivery Anesthesia: None Pericervical block Epidural Spinal block General Local

24. Type of Delivery: C-Section Normal Vaginal Forceps Assisted Vacuum Assisted
 Other (Specify): _____

25. If C-Section, give indication: Breech presentation Cephalopelvic disproportion Fetal distress
 Other (Specify): _____

BIRTH FATHER INFORMATION - facts at the time of the adoptee's birth

26. Number of living children _____ 27. Number of children not living _____

28. Number Miscarriages or induced terminations _____

BIRTH PARENT and FAMILY SOCIAL AND HEALTH HISTORY INFORMATION

Please make additional copies of these pages as needed for each family member you choose to include.

 BIRTH MOTHER BIRTH FATHER MOTHER OF BIRTH MOTHER FATHER OF BIRTH MOTHER MOTHER OF BIRTH FATHER FATHER OF BIRTH FATHER

1. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Married to second birth parent <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		2a. Currently living, or age at death?	2b. Cause of Death?
		3. Enrolled member of a Native American tribe, Alaskan Village or affiliated with a tribe? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list Tribe:	
4. Country or State of birth:		5. Race:	6. Ethnic Heritage:
7. Height:	8. Weight:	9. Eye Color:	10. Hair Color and texture:
11. Complexion: fair, olive, dark etc.		12. Unique physical features:	
13. <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed		14. Physical Build: big/small boned, muscular etc:	
15. Talents, hobbies and other interests:			
16. Describe personality:			
17. Was anyone in your family adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what relation?		18. Your order of birth: Ex: 1st of 4 or 2nd of triplets, 3rd of 5	
19. Other Information:			

Please make additional copies of these pages as needed for each family member you choose to include.

 BIRTH MOTHER BIRTH FATHER MOTHER OF BIRTH MOTHER FATHER OF BIRTH MOTHER MOTHER OF BIRTH FATHER FATHER OF BIRTH FATHER

1. Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Married to second birth parent <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		2a. Currently living, or age at death?	2b. Cause of Death?
		3. Enrolled member of a Native American tribe, Alaskan Village or affiliated with a tribe? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list Tribe:	
4. Country or State of birth:		5. Race:	6. Ethnic Heritage:
7. Height:	8. Weight:	9. Eye Color:	10. Hair Color and texture:
11. Complexion: fair, olive, dark etc.		12. Unique physical features:	
13. <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed		14. Physical Build: big/small boned, muscular etc:	
15. Talents, hobbies and other interests:			
16. Describe personality:			
17. Was anyone in this immediate family adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what relation?		18. Your order of birth and number of siblings: Ex: 1st of 4 or 2nd of triplets, 3rd of 5	
19. Other Information:			

BIRTH PARENT and FAMILY SOCIAL AND HEALTH HISTORY INFORMATION					
Please make additional copies of these pages as needed for each family member you choose to include.					
[] SIBLING OF BIRTH MOTHER [] SIBLING OF BIRTH FATHER [] CHILD OF BIRTH MOTHER [] CHILD OF BIRTH FATHER					
1. Sex: [] Male [] Female [] Unknown/non-binary		2a. Currently living, or age at death?		2b. Cause of Death?	
3. Height:	4. Weight:	5. Eye Color:		6. Hair Color and texture:	
7. Complexion: fair, olive, dark etc.		8. Unique physical features:			
9. [] Right-handed [] Left-handed		10. Physical Build: big/small boned, muscular etc:			
11. Talents, hobbies and other interests:					
12. Describe personality:					
19. Other Information:					
Please make additional copies of these pages as needed for each family member you choose to include.					
[] SIBLING OF BIRTH MOTHER [] SIBLING OF BIRTH FATHER [] CHILD OF BIRTH MOTHER [] CHILD OF BIRTH FATHER					
1. Sex: [] Male [] Female [] Non-binary/Unknown		2a. Currently living, or age at death?		2b. Cause of Death?	
3. Height:	4. Weight:	5. Eye Color:		6. Hair Color and texture:	
7. Complexion: fair, olive, dark etc.		8. Unique physical features:			
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11. Talents, hobbies and other interests:					
12. Describe personality:					
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11. Talents, hobbies and other interests:					
12. Describe personality:					
19. Other Information:					
ADOPTION REGISTRY ONLINE SUBMISSION: AdoptionRegistry.utah.gov ◦ MAILING ADDRESS: PO Box 141012 ◦ SLC, UT 84114-1012 801-538-6105 ◦ Fax 801-538-7012 ◦ vrequest@utah.gov ◦ vitalrecords.utah.gov ◦ UDOH-OVRS-320 July 2021 ◦ Page 3					

BIRTH PARENT FAMILY MEDICAL HISTORY				<input type="checkbox"/> BIRTH MOTHER	<input type="checkbox"/> BIRTH FATHER
CONDITION	NONE	YOU	YOUR BLOOD RELATIVE	COMMENTS	
			(Specify Relationship)		
Baldness					
Birth Defects					
Club foot					
Cleft palate (harelip)					
Congenital heart disease					
Cancer (specify type) Age at onset? Part of body affected?					
Asthma					
Eczema					
Other (specify)					
ALLERGIES:					
Animals					
Food					
Hay fever/plants					
Medications					
Hives					
Other allergies					
Other (specify)					
Other (specify)					
VISUAL:					
Astigmatism					
Blindness					
Color blindness					
Glaucoma					
Nearsighted/farsighted					
Other (specify)					
EMOTIONAL/MENTAL ILLNESS: Age at onset? Treatment? Hospitalization?					
Biopolar (manic-depressive)					
Schizophrenia					
Severe depression					
Suicide					
Obsessive-Compulsive disorder					
Personality disorder					
Alcoholism / drug addiction					
Other (specify)					
Other (specify)					
HEREDITARY DISEASE:					
Cystic fibrosis					
Galactosemia					
Hemophilia					
Huntington's disease					
Other (specify)					

BIRTH PARENT FAMILY MEDICAL HISTORY				<input type="checkbox"/> BIRTH MOTHER	<input type="checkbox"/> BIRTH FATHER
CONDITION	NONE	YOU	YOUR BLOOD RELATIVE	COMMENTS	
			(Specify Relationship)		
CARDIOVASCULAR DISEASE: Age at onset? Outcome?					
Heart Attack					
Heart murmur					
High blood pressure					
Diabetes (specify type)					
Rheumatic fever				Did heart murmur result?	
Other (specify)					
Other (specify)					
SEXUALLY TRANSMITTED DISEASE: Age at onset? Treatment? Hospitalization?					
Syphilis					
HIV / AIDS					
Pelvic inflammatory disease					
Other, esp if birth mother infected at time of birth (specify)					
OTHER DISEASE:					
Hepatitis (A, B or C?)					
Hypo or hyper -thyroidism					
Other (specify)					
NEUROLOGICAL DISORDER: Severity? Treatment? Age at onset? Frequency of events?					
Cerebral palsy					
Muscular dystrophy					
Multiple sclerosis					
Epilepsy / Convulsions (specify)					
Stroke					
Other (specify)					
DEVELOPMENTAL DISORDER: Type of education? Treatment?					
Learning disability/attention deficit (specify type)					
Mental disorder (specify type)					
Down Syndrome					
Speech or hearing problems					
Low birth weight					
Other (specify)					
OTHER: Any other condition that may affect the adoptee					

