Voluntary Medical History for Safe Havens

Both you and your baby deserve a chance. You have taken the first step in making sure that your newborn will be safe and well cared for. We know this decision is difficult, and we respect your choice. We are giving this form to you in order to learn medical information about your child. You may complete all or part of it when you deliver the child. Filling it out is your choice—it is completely voluntary. If you don't fill out this form you will not face legal consequences.

Today's date:	Baby's gender:	Select all that apply:	☐ Native American
	☐ Male	☐ African American	☐ Asian
	☐ Female	☐ Hawaiian/Pacific Islander	☐ Hispanic/Latino
		☐ Caucasian	☐ Other: ________________

ABOUT THE PREGNANCY

While pregnant, did you have any of the following conditions and/or were you exposed to any of the following? (Please check all that apply)

☐ Chicken Pox	☐ High Blood Pressure	☐ Meningitis	☐ X-rays/Radiation
☐ Chlamydia	☐ HIV+/AIDS	☐ Mumps	☐ Sexually Transmitted Infections
☐ Diabetes	☐ Seizures	☐ Tuberculosis (TB)	☐ Other: ________________
☐ Domestic Violence	☐ Visual Disturbances	☐ Infections	
☐ Hazardous Chemicals	☐ Hepatitis	☐ Measles	

FAMILY HEALTH HISTORY

Check if any apply to the birth father, birth mother, or extended family (e.g., aunt, grandparent, etc.)

☐ Allergies: ________________	☐ Down Syndrome	☐ Nervous Breakdown
☐ Anemia	☐ Heart Attack	☐ Schizophrenia
☐ Arthritis/Joint Problems	☐ Heart Murmur	☐ Scoliosis (spinal curvature)
☐ Asthma	☐ Hemophilia/Bleeding Problems	☐ Sickle Cell Anemia
☐ ADD/ADHD	☐ HIV+/AIDS	☐ Skin Problems (eczema, psoriasis, etc.)
☐ Blindness/Visual Problem	☐ Huntington's Disease	☐ Speech Problems
☐ Cancer: ________________	☐ High Blood Pressure	☐ Spina Bifida (born with open spine)
☐ Cerebral Palsy	☐ Intellectual Disability	☐ Stroke
☐ Cystic Fibrosis	☐ Learning Disability	☐ Tay Sachs Disease
☐ Deaf/Hearing Problems	☐ Kidney Problems	☐ Thyroid Disorder
☐ Depression	☐ Multiple Sclerosis (MS)	☐ Other: ________________
☐ Diabetes	☐ Muscular Dystrophy	

Where was the baby born?	Was the baby premature?	Did you receive prenatal care?
☐ Home	☐ Yes (how many weeks): _______	☐ Yes
☐ Hospital	☐ No	☐ No
☐ Other: ________________	☐ Not sure	

Did you take prescribed medications during your pregnancy?	Did you take over-the-counter medications during your pregnancy?
☐ Yes: ________________	☐ Yes: ________________
☐ No	☐ No