MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF VITAL RECORDS

COVER SHEET FOR BIRTH PARENT MEDICAL HISTORY FORM

P.O. Box 570
Jefferson City, Missouri 65102-0570
Telephone: (573) 751-6378

This page will not be released to the adoptee.

The information on this page is for processing purposes only and will be used to help the Bureau of Vital Records identify the adoptee's original (prior to adoption) birth certificate. Please provide as much accurate information as you can to avoid delays and increase the likelihood of being able to process this form. This form will be returned to the sender if the original birth certificate cannot be identified.

The Birth Parent Medical History Form will be placed in a sealed file. It will be released upon request to the adoptee or the adoptee's attorney.

The Bureau of Vital Records cannot accept any additional items including letters or photos. Additional materials cannot be retained and will be discarded.

PLEASE PRINT.

ORIGINAL BIRTH CERTIFICATE INFORMATION

FULL NAME OF CHILD ON ORIGINAL BIRTH CERTIFICATE

CHILD'S DATE OF BIRTH:	CHILD'S SEX	CHILD'S RACE

PLACE OF BIRTH (CITY, COUNTY)	HOSPITAL WHERE CHILD WAS BORN

NUMBER OF LIVE BIRTHS FROM THIS PREGNANCY

MOTHER'S INFORMATION

FULL NAME OF MOTHER ON ORIGINAL BIRTH CERTIFICATE	DATE OF BIRTH

FATHER'S INFORMATION

FULL NAME OF FATHER ON ORIGINAL BIRTH CERTIFICATE	DATE OF BIRTH

BIRTH PARENT'S CURRENT INFORMATION

BIRTH PARENT'S CURRENT NAME (FIRST, MIDDLE, LAST)

BIRTH PARENT'S RELATIONSHIP TO CHILD

☐ Mother ☐ Father

BIRTH PARENT'S CURRENT MAILING ADDRESS - NUMBER AND STREET	CITY, STATE AND ZIP CODE

BIRTH PARENT'S CURRENT TELEPHONE NUMBER

BIRTH PARENT'S SIGNATURE	TODAY'S DATE

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Please do not write on this page.

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Instructions to Birth Parent: All information provided shall pertain to you and your blood relatives. Do not provide information about the other parent.

The information on this form is a confidential communication between the birth parent and adoptee. The information will not be used for any statistical purpose or be disclosed to anyone other than the adoptee or the adoptee's attorney.

I AM THE

☐ Birth Mother ☐ Birth Father

TODAY'S DATE

AS OF TODAY'S DATE, MY AGE RANGE IS

☐ under 20
☐ 20-29
☐ 30-39
☐ 40-49
☐ 50-59
☐ 60 or above

MEDICAL HISTORY FORM OPTIONS

☐ 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.

BIRTH PARENT INFORMATION

RACE

ETHNIC BACKGROUND

BLOOD TYPE

DURING THE PREGNANCY, DID YOU:

Take Prescription Drugs?	☐ No	☐ Yes	Type:
Take Non-Prescription Drugs?	☐ No	☐ Yes	Type:
Use Alcohol?	☐ No	☐ Yes	
Use Cigarettes?	☐ No	☐ Yes	

ARE BIRTH PARENTS RELATED TO EACH OTHER (OTHER THAN BY MARRIAGE)?

☐ No ☐ Yes Relationship:

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Please provide the medical history for you (self) and your blood relatives (such as mother, father, sisters, brothers, grandparents, and any other children).

MEDICAL CONDITIONS	SELF	FAMILY	MEDICAL CONDITIONS	SELF	FAMILY
Respiratory (lungs)			**Endocrine Disorders**		
Allergies (including food/drug allergies)			Diabetes (Adult or Juvenile)		
Asthma			Thyroid (Hyper/Hypo)		
COPD			**Muscular/Skeletal Disorders**		
Emphysema			Club Foot		
Cystic Fibrosis			Scoliosis		
Gastrointestinal (stomach and intestines)			Osteoarthritis		
Ulcers			Rheumatoid Arthritis		
Inflammatory Bowel Disease			Muscular Dystrophy		
Cleft Lip or Palate			Lupus		
Diverticulosis			**Immune/Hematological Disorders**		
Crohn's Disease			Hemophilia		
Irritable Bowel Syndrome			Leukemia (Acute or Chronic)		
Cardiovascular (heart and blood vessels)			Factor V Leiden		
High Blood Pressure			Sickle Cell Anemia		
Heart Attack			**Eye and Ear Disorders**		
Stroke			Blindness		
Heart Disease			Glaucoma		
Heart Rhythm Abnormality			Deafness		
Congenital Heart Defect			**Malignant Conditions**		
Renal Disorders (kidneys)			Cancer - Specify Type:		
Chronic Kidney Disease			**Reproductive Issues**		
Kidney Failure			Fertility Issues		
Liver Disorders			History of Miscarriage		
Hepatitis - Specify Type:			Endometriosis		
Cirrhosis			**Developmental Disorders**		
Nervous System (brain and nerves) Disorders			Learning Disability		
Epilepsy			Autism Spectrum		
Hydrocephalus			Physical Disability		
Multiple Sclerosis			**Mental and Behavioral Disorders**		
Huntington's Disease			Anorexia		
Parkinson's Disease			Substance Abuse (alcohol, illegal drugs, prescription drugs, cigarettes)		
Alzheimer's Disease					
Spina Bifida			Bulimia		
Cerebral Palsy			Bipolar Disorder		
Amyotrophic Lateral Sclerosis			Schizophrenia		
Tay-Sachs Disease			Chronic Depression		

You may submit an updated form by sending a new form to: Bureau of Vital Records, P.O. Box 570, Jefferson City, MO 65102-0570.