Washington State Department of CHILDREN, YOUTH & FAMILIES

Family Genetic and Medical History

Completion of this form is very important to ensure your child receives all necessary medical and mental health services while they are living outside your home. Your medical history as well as any family genetic information will allow for medical and mental health providers to better understand the needs of your child so appropriate care will be provided while in care. Please provide as much information as possible.

Date completed:

Child's Name: _____ Date of birth: _____

Name of person completing this form: _____ What is the relationship to name of child : _____

Section 1: Birth Mother's Background and Family Genetic/Medical History				
YEAR OF BIRTH		RACE		ETHNICITY
HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	RELIGION
☐ LEFT HANDED ☐ RIGHT HANDED	HIGHEST GRADE ACHIEVED	LEARNING CONCERNS		
HOBBIES/INTERESTS/PROFESSION				

BIRTH MOTHER	MEDICAL CONDITION (PLEASE PROVIDE SPECIFIC DIAGNOSES IN THE BLANK BOX, IF APPLICABLE)	AGE OF ONSET, TREATMENT, MEDICATION	RELATIVE/FAMILY MEMBER	RELATIONSHIP TO BIRTH MOTHER	AGE OF ONSET, TREATMENT, MEDICATION
☐	☐ Attention Deficit Disorder (ADD) ☐ Attention Deficit Hyperactivity Disorder (ADHD)		☐		
☐	Allergic reaction (e.g., food, drugs, animals)		☐		
☐	Arthritis		☐		
☐	Birth defects		☐		
☐	Blood-Borne Pathogen (e.g. HIV, AIDS, Hepatitis B, Hepatitis C) ☐ Yes ☐ No		☐		
☐	Blood disorder (e.g., hemophilia, sickle cell anemia)		☐		
☐	Cancer		☐		

BIRTH MOTHER	MEDICAL CONDITION (PLEASE PROVIDE SPECIFIC DIAGNOSES IN THE BLANK BOX, IF APPLICABLE)	AGE OF ONSET, TREATMENT, MEDICATION	RELATIVE/FAMILY MEMBER	RELATIONSHIP TO BIRTH MOTHER	AGE OF ONSET, TREATMENT, MEDICATION
☐	Cardiovascular (e.g., high blood pressure, heart attack, stroke)		☐		
☐	Developmental delays (e.g., difficulty with reading, math, writing, understanding directions, Tourette's syndrome, dyslexia)		☐		
☐	☐ Fetal Alcohol Syndrome (FAS) ☐ Fetal Alcohol Effects		☐		
☐	Gynecological problems/history (e.g., miscarriage, still birth, neonatal death)		☐		
☐	Hearing problems		☐		
☐	Heart defects		☐		
☐	Hormonal disorder (e.g., diabetes, thyroid)		☐		
☐	Learning disability (e.g., neurological, organic brain dysfunction)		☐		
☐	Mental health (e.g. depression, bi-polar, schizophrenia, anxiety)		☐		
☐	Muscle disorder (e.g., muscular dystrophy, multiple sclerosis, cerebral palsy, spina bifida)		☐		
☐	Seizure disorder (e.g., epilepsy, traumatic brain injury)		☐		
☐	Substance use (e.g. alcohol, cannabis (marijuana), prescription drugs, methamphetamine, cocaine, heroin)		☐		
☐	Vision (e.g., near-sighted, far-sighted, blind, glaucoma, cataracts)		☐		
☐	Other known inheritable conditions (please specify)		☐		
☐	Other medical conditions not listed above (please specify)		☐		

Birth Mother Health Status

Describe the birth mother's current health status:

Has the birth mother used any of the following toxic environmental substances and/or controlled substances? ☐ Yes ☐ No ☐ Unknown

If yes, check all that apply and circle specific substance under each category:

☐ Alcohol
☐ Amphetamines
☐ Stimulant (Cocaine, methamphetamine, Ritalin, Adderall, Dexedrine)
☐ Tobacco
☐ Opiates (Morphine, Codeine, Hydrocodone (Vicodin), Fentanyl, Oxycodone (OxyContin, Percocet, Heroin), Suboxone/Methadone)
☐ Benzodiazapine/Tranquilizers (Valium, Xanax, Ativan, Klonopin, etc)
☐ Cannabis (Marijuana)
☐ Other (specify):

Has the birth mother used any substances in the presence of the child? ☐ Yes ☐ No ☐ Unknown

If yes, please check all that apply and circle specific substance under each category:

☐ Alcohol
☐ Amphetamines
☐ Stimulant (Cocaine, methamphetamine, Ritalin, Adderall, Dexedrine)
☐ Tobacco
☐ Opiates (Morphine, Codeine, Hydrocodone (Vicodin), Fentanyl, Oxycodone (OxyContin, Percocet, Heroin))
☐ Benzodiazapine/Tranquilizers (Valium, Xanax, Ativan, Klonopin, etc)
☐ Cannabis (Marijuana)
☐ Other (specify):

Child's Birth History and Current Health

Where was your child born (city, state, hospital)?

Did birth mom have prenatal care? ☐ Yes ☐ No ☐ Unknown ☐ Limited

Was the child exposed to any substances during pregnancy? ☐ Yes ☐ No ☐ Unknown

If yes, please mark the substance, and specify type of substance, how often the substance was used, and during which trimester of the pregnancy:

☐ Controlled substances (specify)	How often & amount used:	Trimester(s):
☐ Prescription drugs (specify)	How often & amount used:	Trimester(s):
☐ Tobacco	How often & amount used:	Trimester(s):
☐ Alcohol	How often & amount used:	Trimester(s):
☐ Other toxic substances (specify)	How often & amount used:	Trimester(s):

Does mother consent to disclose specific type of disease(s) (i.e. hepatitis C, gonorrhea, HIV) the child may have been exposed to in order to provide medical care for the child? ☐ Yes ☐ No

If yes, please have birth mother complete and sign a DCYF 03-475 Consent and attach to the 13-041 (consent to release will only be provided to the child's medical providers and the current caregiver).

Was the child exposed to a blood-borne pathogen or sexually transmitted disease during pregnancy or at birth? ☐ Yes ☐ No ☐ Unknown

If yes, what was the child exposed to?

Were there unusual circumstances noted during labor and delivery:(e.g., c-section, baby stopped breathing, umbilical cord wrapped around neck, loss of blood) ☐ Yes ☐ No ☐ Unknown

If yes, what happened?

Was the child hospitalized in the PICU or NICU after birth? ☐ Yes ☐ No ☐ Unknown

If yes, what was the reason?

Does the child have a history of any medical, dental, or mental health diagnoses? ☐ Yes ☐ No

If yes, what was the child diagnosed with and was there any treatment (please describe type of treatment)?

Does the child have any current medical, dental, or mental health diagnoses or any outstanding needs? ☐ Yes ☐ No

If yes, what is the child diagnosed with and/or the outstanding needs of the child?

Does your child have any allergies? If yes, what are they allergic to and what is the reaction?

Section 2: Birth Father's Background and Family Genetic/Medical History

YEAR OF BIRTH		RACE		ETHNICITY
HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	RELIGION
☐ LEFT HANDED ☐ RIGHT HANDED	HIGHEST GRADE ACHIEVED		LEARNING CONCERNS	
HOBBIES/INTERESTS/PROFESSION				

BIRTH FATHER	MEDICAL CONDITION (PLEASE PROVIDE SPECIFIC DIAGNOSES IN THE BLANK BOX, IF APPLICABLE)	AGE OF ONSET, TREATMENT, MEDICATION	RELATIVE/FAMILY MEMBER	RELATIONSHIP TO BIRTH FATHER	AGE OF ONSET, TREATMENT, MEDICATION
☐	☐ Attention Deficit Disorder (ADD) ☐ Attention Deficit Hyperactivity Disorder (ADHD)		☐		
☐	Allergic reaction (e.g., food, drugs, animals)		☐		
☐	Arthritis		☐		
☐	Birth defects		☐		
☐	Blood-Borne Pathogen (e.g. HIV, AIDS, Hepatitis B, Hepatitis C)		☐		
☐	Blood disorder (e.g., hemophilia, sickle cell anemia) ☐ Yes ☐ No		☐		
☐	Cancer		☐		
☐	Cardiovascular (e.g., high blood pressure, heart attack, stroke)		☐		

BIRTH FATHER	MEDICAL CONDITION (PLEASE PROVIDE SPECIFIC DIAGNOSES IN THE BLANK BOX, IF APPLICABLE)	AGE OF ONSET, TREATMENT, MEDICATION	RELATIVE/FAMILY MEMBER	RELATIONSHIP TO BIRTH FATHER	AGE OF ONSET, TREATMENT, MEDICATION
☐	Developmental delays (e.g., difficulty with reading, math, writing, understanding directions, Tourette's syndrome, dyslexia)		☐		
☐	☐ Fetal Alcohol Syndrome (FAS) ☐ Fetal Alcohol Effects		☐		
☐	Gynecological problems/history (e.g., spontaneous abortion, miscarriage, still birth, neonatal death)		☐		
☐	Hearing problems		☐		
☐	Heart defects		☐		
☐	Hormonal disorder (e.g., diabetes, thyroid)		☐		
☐	Learning disability (e.g., neurological, organic brain dysfunction)		☐		
☐	Mental health (e.g. depression, bi-polar, schizophrenia, anxiety)		☐		
☐	Muscle disorder (e.g., muscular dystrophy, multiple sclerosis, cerebral palsy, spina bifida)		☐		
☐	Seizure disorder (e.g., epilepsy, traumatic brain injury)		☐		
☐	Substance use (e.g. alcohol, cannabis (marijuana), prescription drugs, methamphetamine, cocaine, heroin)		☐		
☐	Vision (e.g., near-sighted, far-sighted, blind, glaucoma, cataracts)		☐		
☐	Other known inheritable conditions (please specify)		☐		
☐	Other medical conditions not listed above (please specify)		☐		

Birth Father Health Status

Describe the birth father's current health status:

Has the birth father used any of the following toxic environmental substances and/or controlled substances? ☐ Yes ☐ No ☐ Unknown

If yes, check all that apply and circle specific substance under each category:

☐ Alcohol
☐ Amphetamines
☐ Stimulant (Cocaine, methamphetamine, Ritalin, Adderall, Dexedrine)
☐ Tobacco
☐ Opiates (Morphine, Codeine, Hydrocodone (Vicodin), Fentanyl, Oxycodone (OxyContin, Percocet, Heroin))
☐ Benzodiazapine/Tranquilizers (Valium, Xanax, Ativan, Klonopin, etc)
☐ Cannabis (Marijuana)
☐ Other (specify):

Has the birth father used any substances in the presence of the child? ☐ Yes ☐ No ☐ Unknown

If yes, please check all that apply and circle specific substance under each category:

☐ Alcohol
☐ Amphetamines
☐ Stimulant (Cocaine, methamphetamine, Ritalin, Adderall, Dexedrine)
☐ Tobacco
☐ Opiates (Morphine, Codeine, Hydrocodone (Vicodin), Fentanyl, Oxycodone (OxyContin, Percocet, Heroin))
☐ Benzodiazapine/Tranquilizers (Valium, Xanax, Ativan, Klonopin, etc)
☐ Cannabis (Marijuana)
☐ Other (specify):