# Voluntary Medical History

## About the Baby

Baby's first name: _____
(if given)

☐ Boy ☐ Girl

Date & time of birth: _____

Place of birth: _____
(Town) (State)

Was the baby premature? ☐ Yes ☐ No

Does the baby have any special needs?
☐ Yes ☐ No

(specify) _____

## About the Parent

While you were pregnant did you?

☐ Smoke cigarettes ☐ Drink alcohol
☐ Take drugs / prescription medications

(specify) _____

| Check all that are known. | Mother | Father |
|---|---|---|
| Asthma | ☐ | ☐ |
| Bipolar Disorder | ☐ | ☐ |
| Depression | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Drug or Alcohol Abuse | ☐ | ☐ |
| Epilepsy or seizures | ☐ | ☐ |
| Headaches or migraines | ☐ | ☐ |
| Heart disease | ☐ | ☐ |
| Hepatitis | ☐ | ☐ |
| High blood pressure | ☐ | ☐ |
| Schizophrenia | ☐ | ☐ |

Other _____

Other _____

Date baby was received: _____

Safe Haven: _____