Crowley Fire Department

VOLUNTARY MEDICAL HISTORY FOR SAFE HAVENS

Safe Baby Moses Site

This form is being provided to you in order to obtain medical information about your child. The form may be fully or partially completed, and may be completed at the same time as delivering the child and no legal consequence will result from failure to complete any part of this. This form is completely voluntary.

Your Name *(optional)*	**Child's Name**	**Date of Birth:**	**Time of Birth:**
Today's Date	**Gender:** ☐ Male ☐ Female	**Check all that apply:** ☐ African American ☐ Hawaiian/Pacific Islander ☐ Caucasian	☐ Native American ☐ Asian ☐ Hispanic/Latino ☐ Other:_____
Mother's Blood Type:	**Father's Blood Type:**		

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

Did you take any of the following during your pregnancy? (*Please check all that apply)*

☐ Alcohol (beer, wine, liquor, etc)	☐ Crack	☐ LSD/Acid
☐ Amphetamines (uppers)	☐ Ecstasy	☐ Marijuana
☐ Barbiturates (downers)	☐ Heroin	☐ Methadone
☐ Caffeine (coffee, soda, etc.)	☐ Inhalants ("huffing")	☐ Tobacco Products
☐ Cocaine	☐ IV Drug Use	☐ Other: _____

FAMILY HEALTH HISTORY

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

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

Where was the baby born?	**Was the baby premature?**	**Did you receive pre-natal 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