The DATZ FOUNDATION

BIRTH MOTHER APPLICATION

Please print these three pages and fill out the application

Due Date _____ Date of Contact_____

BIOLOGICAL MOTHER

Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone (home) _____ (work) _____ (cellular) _____Email _____

Birth date _____ Birthplace _____ Age _____

Religion _____ Race _____

Ancestral Origin (do not use American) _____

Marital Status: *Please check one*: Single ( ) Married ( ) Separated ( ) Divorced ( ) Other ( )

Marital History _____

PHYSICAL DESCRIPTION

Height _____ Weight before pregnancy _____ Weight now _____

Hair color _____ Eye color _____ Complexion: *Please check one*: Fair ( ) Normal ( ) Olive ( ) Tan ( ) Dark ( )

EDUCATIONAL BACKGROUND

Years of school _____

Highest Degree _____

OCCUPATIONAL BACKGROUND

Present Job _____

Years of Employment _____ Previous Employment_____

HOBBIES, TALENTS, AND INTERESTS_____

FAMILY BACKGROUND INFORMATION

Is your family aware of your pregnancy? _____

Do they agree with your plans? _____

Do you live with your family? _____

BIRTH FATHER INFORMATION

Name of Birth Father _____

Address _____

Telephone (home)_____ (work) _____(cellular) _____Email _____

Age _____ Religion _____ Marital Status _____ Race _____

YOUR MOTHER

Name _____

Address _____

Age _____

Health _____

Education _____

Occupation _____

YOUR FATHER

_____

_____

_____

_____

_____

_____

YOUR BROTHERS AND SISTERS

Names _____

Ages _____

Health _____

Occupation _____

INSURANCE COVERAGE

Are you covered?

Social Security Number _____

Driver's License _____ Other _____

PREGNANCY HISTORY

Is this your first pregnancy? _____

If not, how many prior pregnancies? _____

What happened? _____

Abortion _____ Miscarriage _____

Birth _____ Normal_____ C-Section _____

1. Were there any problems with prior pregnancies or births? If so, describe _____

_____

2. Are the children with you now? If not, explain _____

_____

3. History of Children

Name(s) _____ Age(s) _____Sex _____

Health _____

4. Is the father of this child, also the father of any prior children?_____

5. Problems related to this pregnancy: _____

Describe any medications taken during this pregnancy?_____

Have you been involved in any accidents during this pregnancy?_____

Describe_____

Do you smoke? _____ Describe _____

Do you drink? _____ Describe _____

Do you use drugs? _____ Describe_____

GENERAL INFORMATION

Is the father of the child aware of your pregnancy? Yes ( ) No ( )

Does he know of your plans with regard to your placing the child for adoption? Yes ( ) No ( )

MEDICAL INFORMATION

Are you seeing a doctor with respect to this pregnancy? _____If so, name and address _____Tel Number _____

Name of hospital you will deliver in_____

Please report to the best of your knowledge:

	You	Your Family	Father	His Family
AIDS				
CANCER				
CEREBRAL PALSY				
DIABETES				
ASTHMA				
EPILEPSY				

You	Your Family	Father	His Family
KIDNEY DISEASE			
DOWNSYNDROME			
VENEREAL DISEASE			
RETARDATION			
NERVOUS CONDITION			
EMOTIONAL CONDITION			
PHYSICAL HANDICAP			
BLINDNESS			
DEAFNESS			
THYROID DISORDER			
MENTALILLNESS			
CONGENITAL DEFORMITY			
HEART DISEASE			
MUSCULAR DYSTROPHY			
TUBERCULOSIS			
LOW BLOOD PRESSURE			
HIGH BLOOD PRESSURE			
SPINA BIFIDA			
SPEECH PROBLEMS			
LEARNING DISABILITY			
HARELIP/CLEFT PALATE			
CLUBFOOT			
ALCOHOLISM			
DRUG ABUSE			
MULTIPLE SCLEROSIS			
SKINDISORDER			
ECZEMA			
LEUKEMIA			
ULCER			
PARKINSON'S DISEASE			
ALZHEIMER'S DISEASE			
HUNTINGTON'SDISEASE			
TAY-SACH'S DISEASE			
OTHER			
ALLERGIES: FOODS			
MEDICINE:			
LOCAL ANESTHETICS			
PENICILLIN			
ANTIBIOTICS			
SULFA DRUGS			
CODEINE			
ASPIRIN			
IODINE			
OTHERS			

Would you consent to an AIDS test? _____

Date of last AIDS test? _____ Results _____

Name _____ Date _____