Arkansas Department of Health
Vital Records
4815 West Markham Street
Little Rock, AR 72205

NEW RECORDS SYSTEM FOR BIRTH PARENTS

FAMILY HISTORY INFORMATION

B

For a birth parent's Contact Preference Form or Redaction Request Form to be accepted, he or she must submit this form if his or her genetic or social history was not previously compiled or was compiled but needs to be corrected or expanded.

ORIGINAL BIRTH CERTIFICATE INFORMATION

Please provide complete and accurate information. While the Department will diligently search its files for an adoption record that matches your request, it does not warrant, promise or guarantee that it will be able to locate an adoption record that matches the information you provide in your request.

CHILD'S INFORMATION

Child's FIRST Name on Child's Original Birth Certificate:

Child's MIDDLE Name on Child's Original Birth Certificate:

Child's LAST Name on Child's Original Birth Certificate:

Suffix:

Note: If you are unsure of the exact date of the child's birth, please enter your best estimate.

Child's Date of Birth: ☐Actual ☐ Estimate

Country of Birth:

State of Birth:

County of Birth:

City of Birth:

MOTHER'S INFORMATION

Mother's FIRST Name on Child's Original Birth Certificate:

Mother's MIDDLE Name on Child's Original Birth Certificate:

Mother's LAST Name on Child's Original Birth Certificate:

Mother's Date of Birth:

FATHER'S INFORMATION

Father's FIRST Name on Child's Original Birth Certificate:

Father's MIDDLE Name on Child's Original Birth Certificate:

Father's LAST Name on Child's Original Birth Certificate:

Father's Date of Birth:

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FAMILY HISTORY INFORMATION

BIRTH PARENT INFORMATION

NOTE: The birth parent information requested below is for processing purposes and will not be released to a requester if you wish to retain your privacy.

Birth Parent's Current First Name:

Birth Parent's Current Middle Name:

Birth Parent's Current Last Name:

Birth Parent's Date of Birth:

Birth Parent's Relationship to Child: ☐Mother ☐ Father

Phone 1: ☐Home☐ Mobile☐Work

Phone 2: ☐Home☐ Mobile☐Work

Phone 3: ☐Home☐ Mobile☐Work

Email Address:

Mailing Address:

City: State: Zip:

BIRTH PARENT DEMOGRAPHIC INFORMATION

Current age: Eye Color: Blood Type:

Height (inches): Hair Color: Primary Language Spoken:

Weight (lbs.): Race: Nationality (Citizenship):

Religion: Skin Color:

Highest Level of Education: Ethnic Background:

Your Birth Place:

County: State: City:

Country if not USA:

BIOLOGICAL INFORMATION ON DECEASED FAMILY MEMBERS

List your family members who have passed away, age at death and cause of death. Please use these relationship choices: Mother, Father, Son, Daughter, Maternal Grandmother, Maternal Grandfather, Paternal Grandmother, Paternal Grandfather, Sister, Brother, Aunt, Uncle or Adoptee's Other Biological Parent.

Relationship: Age of Death: Cause of Death:

Relationship: Age of Death: Cause of Death:

Relationship: Age of Death: Cause of Death:

Relationship: Age of Death: Cause of Death:

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FAMILY HISTORY INFORMATION

BIOLOGICAL INFORMATION ON DECEASED FAMILY MEMBERS, CONTINUED

Relationship:	Age of Death:	Cause of Death:
Relationship:	Age of Death:	Cause of Death:
Relationship:	Age of Death:	Cause of Death:
Relationship:	Age of Death:	Cause of Death:
Relationship:	Age of Death:	Cause of Death:
Relationship:	Age of Death:	Cause of Death:
Relationship:	Age of Death:	Cause of Death:
Relationship:	Age of Death:	Cause of Death:

MEDICAL HISTORY

For each of the conditions listed below, please check the appropriate column indicating whether you or any of your blood relatives (mother, father, sisters, brothers, grandparents, aunts, or uncles) or any of your other biological children have ever had the condition(s) listed. Comments should include information on age of onset or diagnosis, treatments received or hospitalizations for condition, etc.

Note: All fields under this section are required.

CONDITION	RESPONSE		COMMENTS
Congenital Heart Defect	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Congestive Heart Failure	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Atherosclerosis	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Arrhythmia (abnormal heart rate)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Hypertension (High Blood Pressure)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Stroke	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Heart Attack	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Other Cardiovascular Problems	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Cerebral Palsy	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	

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FAMILY HISTORY INFORMATION

MEDICAL HISTORY, CONTINUED			
Seizures, Convulsions or Epilepsy	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Speech Problem	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Muscular Dystrophy	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Parkinson's Disease	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Alzheimer's or Other Dementia	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Multiple Sclerosis (MS)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Other Paralysis or Crippling Disorder	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Chronic Bronchitis	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Emphysema	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Asthma	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
COPD	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Tuberculosis (TB)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Kidney Disease	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Chronic Anemia	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Sickle Cell Anemia	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Thrombocytopenia (low platelets)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Blood Clots	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Easy Bleeding	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	

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MEDICAL HISTORY, CONTINUED

Other Blood Problems	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Blood or Protein in the Urine	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Missing or Malformed Kidney(s)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Kidney Failure/Kidney Transplant	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Other Kidney Problems	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Pyloric Stenosis	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Bowel Mal-rotation	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Chronic Diarrhea/Malabsorption	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Inflammatory Bowel Disease (Crohns, Ulcerative Colitis, etc.)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Situs Inversus	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Other Problems with Stomach or Bowels	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Tay-Sachs Disease	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
PKU	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Albinism	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Scoliosis	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Osteoporosis	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Multiple Fractures	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Any Other Skeletal Malformations	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	

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MEDICAL HISTORY, CONTINUED

Short Stature (very short height)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Thyroid Disorder	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Diabetes	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Hypoglycemia	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Any Other Hormonal Disorder	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Schizophrenia	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Bipolar Disorder	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Chronic Depression	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Anxiety Disorder	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Suicide (either attempted or Death by suicide)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Alcoholism	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Addiction to Tobacco	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Addiction to Narcotics	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Addiction to Cocaine	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Other Drug Use Disorders	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Anorexia or Bulimia	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Any Other Mental or Emotional Illness	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Eczema or Other Skin Conditions	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	

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MEDICAL HISTORY, CONTINUED			
Intellectual Disability/Cognitive Impairment	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Learning Disability	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Speech-language Disorder	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Mental or Physical Development Deficiencies	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Autism Spectrum	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Attention Deficit and Hyperactivity Disorder (ADHD)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Club Foot	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Cleft Lip or Palate	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Spinal Bifida/Other Neural Tube Defects	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Down's Syndrome	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Trisomy 13 or 18	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Turner Syndrome	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Klinefelter Syndrome	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Cystic Fibrosis	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Huntington's Disease	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Breast Cancer	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Ovarian Cancer	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Colon Cancer	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	

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MEDICAL HISTORY, CONTINUED			
Leukemia (Blood Cancer)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Prostate Cancer	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Lung Cancer	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Cancer (Other)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Immune Deficiency	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Autoimmune Disorder (Lupus, Rheumatoid Arthritis)	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Hay Fever or Other Allergies	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Food or Drug Allergies	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Eczema	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Psoriasis	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Ichthyosis	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Other Skin Conditions	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Blindness or Glaucoma	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Macular Degeneration	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Retinal Disorder	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Cataracts	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Other Vison Problems	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Deafness or Other Ear Problems	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	

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MEDICAL HISTORY, CONTINUED			
Any Other Conditions You or Others in Your Family May Have	☐No ☐Not Known	☐Yes (Self) ☐Yes (Relative)	
Prescription Drugs Taken During Pregnancy	☐No ☐Not Known	☐Yes (Self)	
Non-Prescription Drugs Taken During Pregnancy	☐No ☐Not Known	☐Yes (Self)	
Alcohol Use During Pregnancy	☐No ☐Not Known	☐Yes (Self)	
Amphetamines, Barbiturates or Opioids Used During Pregnancy	☐No ☐Not Known	☐Yes (Self)	
Are birth parents related to each other (other than by marriage)?	☐No ☐Not Known	☐Yes (Self)	
Were there special circumstances surrounding conception, pregnancy or delivery?	☐No ☐Not Known	☐Yes (Self)	
Can you provide information about the mother's reproductive life (for example, the age at first menses; age at menopause, miscarriages or fertility issues)?	☐No ☐Not Known	☐Yes (Self)	

Please provide any additional information related to the Medical/Social/Cultural History section:

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FAMILY HISTORY INFORMATION

By signing, I certify that I am the birth parent of the adoptee and, that to the best of my knowledge, the information I am supplying is correct and accurate. I understand that if I falsely represent that I am the birth parent of the adoptee on this form, then I may be subject to penalties pursuant to Ark. Code Ann. § 20-18-105.

Signature of Birth Parent: _____ Date: _____

State of Arkansas

County of _____

On this the _____ day of _____, 20____, before me, _____, the undersigned notary, personally appeared (name of signer) known to me (or satisfactorily proven) to be the person whose name is subscribed to the instrument and acknowledged that he/she executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand and official seal.

_____ (Seal of Office)

Signature of Notary Public

My Commission expires: _____