Corsicana Fire Rescue

VOLUNTARY MEDICAL HISTORY FOR SAFE HAVENS

County		Today's Date

Child's First Name	Birth Date	Check all that apply	
		☐ African American	☐ Asian
☐ Male ☐ Female	Time of Birth	☐ Hawaiian/Pacific Islander	☐ Hispanic/Latino
		☐ Native American	☐ Other _____
			☐ Caucasian

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 the box that applies to you.)

- ☐ Chicken Pox
- ☐ Chlamydia
- ☐ Diabetes (high sugar)
- ☐ Domestic Violence
- ☐ Hazardous Chemicals
- ☐ Headaches/Seizures
- ☐ Visual Disturbance
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Infections
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Tuberculosis (TB)
- ☐ X-Rays/Radiation
- ☐ SexuallyTransmitted Disease/ Veneral Disease
- ☐ Other _____

Did you take any of the following during your pregnancy? *Check only those that apply.*

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

FAMILY HEALTH HISTORY

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

- ☐ Allergies -Type _____
- ☐ Anemia
- ☐ Arthritis/Joint Problems
- ☐ Asthma
- ☐ Attention Deficit/Hyperactivity
- ☐ Blindness/Visual Problem
- ☐ Cancer(s) -Type _____
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Deaf/Hearing Problems
- ☐ Depression
- ☐ Diabetes (high sugar)
- ☐ Down's Syndrome
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hemophilia/Bleeding
- ☐ Problems
- ☐ HIV+/AIDS
- ☐ Huntington's Disease
- ☐ Hypertension (high blood pressure)
- ☐ Kidney Problems
- ☐ Learning Disabilities
- ☐ Mental Retardation
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Nervous Breakdown
- ☐ Schizophrenia
- ☐ Scoliosis (spinal curvature)
- ☐ Sickle Cell Anemia
- ☐ Skin Problems (psoriasis, eczema, acne)
- ☐ Speech Problems
- ☐ Spina Bifida (born with open spine)
- ☐ Stroke
- ☐ Tay Sachs Disease
- ☐ Thyroid Disorder
- ☐ Other _____
  _____

Was the baby born?
☐ At Home ☐ At the Hospital
☐ Other: please explain

Was the baby premature?
☐ Yes ☐ No ☐ Not sure
If Yes, how many weeks premature?

Did you receive pre-natal care?
☐ Yes ☐ No

Did you take prescribed medication(s) during your pregnancy?
☐ Yes ☐ No
If yes, what?

Did you take over-the-counter medication(s) during your pregnancy?
☐ Yes ☐ No
If yes, what?

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 or at a later time. This form is completely voluntary.