CONNECTICUT

Department of Children & Families

MEDICAL INFORMATION ON GENETIC PARENT
DCF-338
(Rev. 09/2024)

☐ Mother	***(Use separate form for each parent)***		☐ Father
Indicate by checking "Yes" or "No" if you or any genetic relatives (i.e. your mother, father, sisters, brothers, grandparents, aunts, uncles, or any other children you have had) ever had, or now have, the medical items listed. Also complete the "Comment" section.			
Medical Condition	**Self**	**Yes – Relative** *(Specify which relative)*	**Yes – Relative** *(Specify which relative)*
Allergies	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Asthma/Respiratory issues	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Cancer	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Cardiac Disease	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Diabetes	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Hypertension	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Mental Health Diagnosis	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Muscular/Skeletal Issues	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Epilepsy/Seizure Disorder	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Visual Concerns	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Educational/Learning Disabilities	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Eczema or other skin conditions	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Sickle Cell	☐ No ☐ Yes ☐ Don't Know		
	Explain:		

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Alcohol Use	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Drug Use	☐ No ☐ Yes ☐ Don't Know		
	Explain:		
Any other condition you or others in your family might have	☐ No ☐ Yes ☐ Don't Know		
	Explain		

Genetic Mother Age at onset of Menses			
Please list all your pregnancies in order. (Use one line for each child or for each miscarriage, abortion, or still birth.)			
Children: (write: boy, girl, abortion, miscarriage, or still-birth)	How Many Months Did You Carry This Pregnancy?	Year in Which Pregnancy Ended	If Miscarriage or Abortion, Was it Natural or Induced?

CURRENT PREGNANCY	
Is the baby's father aware of this pregnancy? ☐ Yes ☐ No ☐ Not Sure	Is the baby's father a genetic relative of yours? ☐ Yes ☐ No If "Yes", how is he related?
What month did prenatal care begin for this baby?	Any Complications?
Any exposure during this pregnancy? ☐ X-ray ☐ Electrocardiogram ☐ Radiation	
DRUGS TAKEN DURING PREGNANCY	
List Prescription Drugs, frequency and dosages:	
List Non-Prescription Drugs frequency and dosages (including aspirin and/or nose drops) When and frequency during pregnancy	

SUBSTANCE:	Yes/No	If "Yes", What kind?:	Amount?:	How Often?:
Alcohol	☐ Yes ☐ No			
Amphetamines *(Uppers)*	☐ Yes ☐ No			
Barbiturates *(Downers)*	☐ Yes ☐ No			
Cigarettes	☐ Yes ☐ No			
Cocaine	☐ Yes ☐ No			
Heroin	☐ Yes ☐ No			
K2	☐ Yes ☐ No			
Marijuana	☐ Yes ☐ No			
Opioids	☐ Yes ☐ No			
Other	☐ Yes ☐ No			

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505 Hudson Street
Hartford, CT 06106
Phone: 860-550-6300

CHILD'S BIRTH AND MEDICAL HISTORY				
Child's 1st Name:	DOB:	Time:	Gender:	Weight: lbs oz
Term: ☐ Premature ☐ Full ☐ Postmature	Pregnancy occurred at (# of Weeks):			
Duration of Labor:	Anesthesia Used:			
Type of Delivery:	Apgar score at 1 minute:	Apgar score at 5 minutes:		
Head Circumference	Chest Circumference			
Condition of Child at Birth/ Any Abnormalities:				
Mother's Blood Type	Rh Factor:	Baby's Blood Type:		
First Tooth at *(months):*	Sat Alone at *(months):*	Walked at *(months):*	Toilet Trained at *(months):*	
Diagnosed Medical Conditions *(i.e., allergies, asthma, bronchitis, etc.):*				

HOSPITALIZATIONS
Any Hospitalizations? (Reason, Date(s) and Place(s):

EVALUATIONS / EXAMINATIONS		
Please complete the following Type of Tests:	Date	Performed by:
Psychological Evaluations		
Psychiatric Evaluation		
Intellectual Assessment		
Developmental Evaluation *(Speech, Language, Hearing)*		
Neurological Evaluation		
OTHER:		

ATTACH IMMUNIZATION RECORD

I hereby acknowledge receipt of a copy of this form.	Signature of Adoptive Parent 1:		Date:
	Signature of Adoptive Parent 2:		Date:
Name of Agency:			
Address (No. and Street)	City:	State:	Zip:
Agency Representative Name:	Agency Representative Signature		Date

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