New Jersey Department of Health
Vital Statistics and Registry
PO Box 370
Trenton, NJ 08625-0370

NEW RECORDS SYSTEM FOR BIRTH PARENTS

FAMILY HISTORY INFORMATION

B

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:

Child's Date of Birth: __ __ / __ __ / __ __ __ __ ☐ Actual ☐ Estimate

Sex: ☐ Male ☐ Female

Country of Birth:

State of Birth:

County of Birth:

Municipality 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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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 at this time.

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:

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BIRTH PARENT DEMOGRAPHIC INFORMATION

Your 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 Place of Birth:

Country:		State:		City:	

BIOLOGICAL INFORMATION ON DECEASED FAMILY MEMBERS

List your family members who have passed away, age at death, and cause of death:

Relationship*:		Age at Death:		Cause of Death:	
Relationship*:		Age at Death:		Cause of Death:	
Relationship*:		Age at Death:		Cause of Death:	
Relationship*:		Age at Death:		Cause of Death:	
Relationship*:		Age at Death:		Cause of Death:	
Relationship*:		Age at Death:		Cause of Death:	
Relationship*:		Age at Death:		Cause of Death:	
Relationship*:		Age at Death:		Cause of Death:	
Relationship*:		Age at Death:		Cause of Death:	
Relationship*:		Age at Death:		Cause of Death:	
Relationship*:		Age at Death:		Cause of Death:	
Relationship*:		Age at Death:		Cause of Death:	

**Relationship choices:* *•Mother •Son •Maternal Grandmother •Paternal Grandmother •Sister •Aunt •Father •Daughter •Maternal Grandfather •Paternal Grandfather •Brother •Uncle •Other Biological Parent*

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MEDICAL HISTORY

For each of the medical 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 other of your children have 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.

HEART AND BLOOD VESSELS

Medical 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)	
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)	

BRAIN AND NERVES

Medical Condition	Response		Comments
Cerebral Palsy	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Seizures, Convulsions or Epilepsy	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	

LUNGS

Medical Condition	Response		Comments
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)	
Hay Fever or Other Allergies; Food or Drug Allergies	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Tuberculosis	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	

KIDNEY

Medical Condition	Response		Comments
Kidney Disease	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	

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MEDICAL HISTORY, CONTINUED

For each of the medical 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 other of your children have 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.

BLOOD DISORDER

Medical Condition	Response		Comments
Sickle Cell Anemia or Tay-Sachs Disease	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	

JOINTS / SKELETON

Medical Condition	Response		Comments
Scoliosis	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Any Other Malformations	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	

ENDOCRINE (GLANDS)

Medical Condition	Response		Comments
Thyroid Disorder	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Diabetes	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Other Hormonal Disorder	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	

PSYCHOSOCIAL

Medical Condition	Response		Comments
Schizophrenia, Bipolar Disorder, or Chronic Depression	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Alcoholism, Drug Addiction or Tobacco Use	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Anorexia or Bulimia	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Other Mental or Emotional Illnesses	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	

SKIN DISORDERS

Medical Condition	Response		Comments
Eczema or Other Skin Conditions	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	

DEVELOPMENTAL

Medical Condition	Response		Comments
Learning Disability	☐ 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)	

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MEDICAL HISTORY, CONTINUED

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NEUROLOGICAL

Medical Condition	Response		Comments
Blindness, Glaucoma or Other Visual Problems	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Deafness or Other Ear Problems	☐ 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)	

GENETIC

Medical Condition	Response		Comments
Club Foot, Cleft Lip or Palate	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Down's Syndrome	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	

MOTOR DEFICIENCIES

Medical Condition	Response		Comments
Multiple Sclerosis	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Other Paralysis or Crippling Disorder	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	

CANCER

Medical Condition	Response		Comments
Cancer (Breast, Ovarian, Cervical, Prostate, etc.)	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	
Tumors	☐ 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)	

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MEDICAL HISTORY, CONTINUED

For each of the medical 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 other of your children have 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.

OTHER CONDITIONS

Medical Condition	Response		Comments
Any Other Conditions You or Others in Your Family May Have	☐ No ☐ Not Known	☐ Yes (Self) ☐ Yes (Relative)	

SOCIAL/CULTURAL BACKGROUND

Cultural Background	Response		Comments
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 or Barbiturates 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:

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 N.J.S.A. 26:8-69.

Signature of Birth Parent: _____ Date: _____