**DEPARTMENT OF CHILDREN AND FAMILIES** Adoption Records Search Program

Division of Safety and PermanencePO Box 8916

Madison, WI 53708-8916

(608) 422-6928

**Family History Questionnaire**

**Medical / Genetic**

**Use of form:** This form is used to collect biological family medical and genetic history for any child whose biological parent has terminated parental rights to that child in Wisconsin. Completion of this form meets the requirements of s. 48.425(1)(am), Wis. Stats. Any biological parent whose parental rights are being terminated in a Wisconsin court is required to complete this form at the time of the termination of parental rights proceeding. If a birth parent is adopted, only biological family information should be included. This form is also used to update medical / genetic history by any birth parent who has terminated their parental rights to a child in Wisconsin at any time. Another individual may complete this form on behalf of a birth parent if the birth parent is unable to do so. Personally identifiable information on this form is confidential and will be used only for identification purposes.

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| **The information on this form pertains to:**  **Birth Mother**  **Birth Father** | | | | | | | | |
| **SECTION I INFORMATION ABOUT BIRTH PARENT AND CHILD PLACED FOR ADOPTION** | | | | | | | | |
| Name – Child (Last, First, Middle) | | | | Birthdate (mm/dd/yyyy) | | | Birthplace (City, State) | |
| Name – Hospital | | | | Name – Attending Physician | | | | |
| Name (Current) – Birth Mother (Last, First, Middle) | | | | Name – Maiden (Last) | | | Birthdate (mm/dd/yyyy) | |
| Address – Permanent (Street, City, State, Zip Code) | | | | | | | Telephone Number | |
| Name – Birth Father (Last, First, Middle) | | | | | | | Birthdate (mm/dd/yyyy) | |
| Address – Permanent (Street, City, State, Zip Code) | | | | | | | Telephone Number | |
| Yes  No Are the birth parents related to each other in any way or do they have blood ties? If "Yes", specify relationship: | | | | |  | | | |
| **SECTION II PROVIDER OF INFORMATION IF NOT COMPLETED BY BITH PARENT** | | | | | | | | |
| Name – Individual Providing Information on Behalf of Birth Parent | | | Address – Current (Street, City, State, Zip Code) | | | | | |
| Telephone Number | | | Relationship to Child | | | | | |
| Name – Agency Staff Person Reviewing Questionnaire | | | Name – Agency | | | | | Telephone Number |
| **SECTION III DESCRIBE BIRTH PARENT AND HIS / HER PARENTS** | | | | | | | | |
|  | **Birth Parent** | **Your Mother** | | | | **Your Father** | | |
| Name (Last, First, Middle) |  |  | | | |  | | |
| Birthdate (mm/dd/yyyy) |  |  | | | |  | | |
| Height and weight |  |  | | | |  | | |
| Ethnic / national background |  |  | | | |  | | |

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|  | **Birth Parent** | | | | | | **Your Mother** | | | | | | | **Your Father** | | | |
| Racial group (Check one) | White (not Hispanic)  Black (not Hispanic)  Hispanic  Alaskan Native  American Indian  Yes  No Enrolled | | | | | | White (not Hispanic)  Black (not Hispanic)  Hispanic  Alaskan Native  American Indian  Yes  No Enrolled | | | | | | | White (not Hispanic)  Black (not Hispanic)  Hispanic  Alaskan Native  American Indian  Yes  No Enrolled | | | |
|  | Name of Tribe: | | | | | | Name of Tribe: | | | | | | | Name of Tribe: | | | |
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|  | Asian or Pacific Islander | | | | | | Asian or Pacific Islander | | | | | | | Asian or Pacific Islander | | | |
|  | Other: | |  | | | | Other: | | |  | | | | Other: | |  | |
|  |  | |  | | | |  | | |  | | | |  | |  | |
| Occupation |  | | | | | |  | | | | | | |  | | | |
| Education completed. Indicate highest grade or if attended special education classes. |  | | | | | |  | | | | | | |  | | | |
| If deceased, age at death and cause of death, if known. |  | | | | | |  | | | | | | |  | | | |
| Are you of Ashkenazi Jewish descent? | Yes  No | | | | | | Yes  No | | | | | | | Yes  No | | | |
| ARE YOU ADOPTED? | Yes  No | | | | | | Yes  No | | | | | | | Yes  No | | | |
| **SECTION IV DESCRIBE BIRTH PARENT'S BROTHERS AND SISTERS** | | | | | | | | | | | | | | | | | |
| If additional space is needed, attach separate sheet. | | | | | | | | | | | | | | | | | |
| **Name – Current (Last, First, Middle)** | | | | **Maiden** | **Relationship** | **Gender** | | | **Birthdate** | | **Height** | **Weight** | **Sibling’s Children** | | | | **If Deceased, Cause and Age at Death, if Known** |
| 1. | | | | | Full  Half  Step | Male  Female | | |  | |  |  | No. of males:  No. of females: | | | |  |
| 2. | | | | | Full  Half  Step | Male  Female | | |  | |  |  | No. of males:  No. of females: | | | |  |
| 3. | | | | | Full  Half  Step | Male  Female | | |  | |  |  | No. of males:  No. of females: | | | |  |
| 4. | | | | | Full  Half  Step | Male  Female | | |  | |  |  | No. of males:  No. of females: | | | |  |
| 5. | | | | | Full  Half  Step | Male  Female | | |  | |  |  | No. of males:  No. of females: | | | |  |
| 6. | | | | | Full  Half  Step | Male  Female | | |  | |  |  | No. of males:  No. of females: | | | |  |

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| **SECTION V DESCRIBE BIRTH PARENT'S GRANDPARENTS** | | | | |
| **Category** | **Maternal Grandmother** | **Maternal Grandfather** | **Paternal Grandmother** | **Paternal Grandfather** |
| Name – Current  (Last, First, Middle) |  |  |  |  |
| Height and weight |  |  |  |  |
| Ethnic / national background |  |  |  |  |

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| Racial group  (Check one) | White (not Hispanic)  Black (not Hispanic)  Hispanic  Alaskan Native  American Indian  Yes  No Enrolled? | | | White (not Hispanic)  Black (not Hispanic)  Hispanic  Alaskan Native  American Indian  Yes  No Enrolled? | | | White (not Hispanic)  Black (not Hispanic)  Hispanic  Alaskan Native  American Indian  Yes  No Enrolled? | | | White (not Hispanic)  Black (not Hispanic)  Hispanic  Alaskan Native  American Indian  Yes  No Enrolled? | | |
|  | Name of Tribe: | | | Name of Tribe: | | | Name of Tribe: | | | Name of Tribe: | | |
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|  | Asian or Pacific Islander | | | Asian or Pacific Islander | | | Asian or Pacific Islander | | | Asian or Pacific Islander | | |
|  | Other: | |  | Other: | |  | Other: | |  | Other: | |  |
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| Education completed. Indicate highest grade or if attended special education. |  | | |  | | |  | | |  | | |

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| If deceased, age at death and cause of death, if known. | |  | |  | | | |  | | |  | |
| **SECTION VI DESCRIBE BIRTH PARENT'S OTHER CHILDREN** | | | | | | | | | | | | |
| List in order of birth. Include pregnancy losses, stillbirths, and miscarriages. If deceased, indicate age at death and cause, if known. If additional space is needed, attach separate sheets. | | | | | | | | | | | | |
| **Name (Last, First, Middle)** | | | **Relationship To**  **Child Placed For Adoption** | | **Gender** | **Birthdate** | **Height** | | **Weight** | **Health / Medical Problems** | | **If Deceased, Cause and Age at Death, if Known** |
| 1. |  | | Full  Half  Step | | Male  Female |  |  | |  |  | |  |
| 2. |  | | Full  Half  Step | | Male  Female |  |  | |  |  | |  |
| 3. |  | | Full  Half  Step | | Male  Female |  |  | |  |  | |  |
| 4. |  | | Full  Half  Step | | Male  Female |  |  | |  |  | |  |

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| **Name (Last, First, Middle)** | | | | | | **Relationship To**  **Child Placed For Adoption** | | **Gender** | **Birthdate** | | **Height** | **Weight** | | **Health / Medical Problems** | | **If Deceased, Cause and Age at Death, if Known** |
| 5. |  | | | | | Full  Half  Step | | Male  Female |  | |  |  | |  | |  |
| 6. |  | | | | | Full  Half  Step | | Male  Female |  | |  |  | |  | |  |
| **SECTION VII MEDICAL / GENETIC HISTORY** | | | | | | | | | | | | | | | | |
| Indicate by checking "Yes" or "No" if this child or any blood relatives ever had or now have the medical conditions listed. Complete the "Comments" section, indicating age when condition began and specific diagnosis and treatment; indicate if 'UNKNOWN". Indicate all relatives in terms of their relationship to birth parent as listed in the following code section. | | | | | | | | | | | | | | | | |
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| **CODE** | | **IMMEDIATE FAMILY** | **CODE** | | **FEMALE RELATIVES** | | | | | | | | **CODE** | | **MALE RELATIVES** | |
| BP | | Birth parent | M | | Birth parent's mother (child's grandmother) | | | | | | | | F | | Birth parent's father (child's grandfather) | |
| OC | | Birth parent's other child | S | | Birth parent's sister (child's aunt) | | | | | | | | B | | Birth parent's brother (child's uncle) | |
|  | |  | NE | | Birth parent's niece (child's cousin) | | | | | | | | NEP | | Birth parent's nephew (child's cousin) | |
|  | |  | MGM | | Birth parent's maternal grandmother (your mother's mother) | | | | | | | | MGF | | Birth parent's maternal grandfather (your mother's father) | |
|  | |  | PGM | | Birth parent's paternal grandmother (your father's mother) | | | | | | | | PGF | | Birth parent's paternal grandfather (your father's father) | |
|  | |  | OF | | Other female relative (specify in comments) | | | | | | | | OM | | Other male relative (specify in comments” | |
|  | | | | | | | | | | | | | | | | |
| **Medical Condition** | | | | **No** | | **Do Not**  **Know** | **If “Yes”, who?**  **(See codes above)** | | | **Comments; i.e., age at onset, specific diagnosis and treatment.**  **If additional space is needed, attach a separate sheet.** | | | | | | |
| 1. Glasses (near / farsighted,  cross-eyed, astigmatic, etc.) | | | |  | |  |  | | |  | | | | | | |
| 2. Blindness or other visual problems; e.g., glaucoma, cataracts | | | |  | |  |  | | |  | | | | | | |
| 3. Tay-Sachs disease | | | |  | |  |  | | |  | | | | | | |
| 4. Deafness, hearing disabilities | | | |  | |  |  | | |  | | | | | | |
| 5. Speech problems | | | |  | |  |  | | |  | | | | | | |
| 6. Dental problems; e.g., missing or extra teeth | | | |  | |  |  | | |  | | | | | | |
| 7. Cleft lip | | | |  | |  |  | | |  | | | | | | |
| 8. Cleft palate | | | |  | |  |  | | |  | | | | | | |
| 9. Learning disability, dyslexia or other  disabilities | | | |  | |  |  | | |  | | | | | | |
| 10. Mental retardation | | | |  | |  |  | | |  | | | | | | |
| 11. Special education | | | |  | |  |  | | |  | | | | | | |
| 12. Attention Deficit Disorder (ADD),  Attention Deficit Hyperactivity Disorder (ADHD) | | | |  | |  |  | | |  | | | | | | |

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| **Medical Condition** | **No** | **Do Not**  **Know** | **If “Yes”, who?**  **(See codes on page 4)** | **Comments; i.e., age at onset, specific diagnosis and treatment.**  **If additional space is needed, attach a separate sheet.** |
| 13. Down syndrome |  |  |  |  |
| 14. Other chromosomal disorder |  |  |  |  |
| 15. Mental illness; e.g., bipolar disorder, schizophrenia, depression |  |  |  |  |
| 16. Suicide |  |  |  |  |
| 17. Emotional problems |  |  |  |  |
| 18. Autism |  |  |  |  |
| 19. Frequent headaches; e.g., tension, migraine |  |  |  |  |
| 20. Hydrocephalus |  |  |  |  |
| 21. Microcephalus (small head) |  |  |  |  |
| 22. Patches of hair of different color (pigment) |  |  |  |  |
| 23. Patches of skin of different color; e.g., pigment or white spots |  |  |  |  |
| 24. Birthmarks; e.g., unusual configuration, size, or number |  |  |  |  |
| 25. Eczema, acne and other skin problems |  |  |  |  |
| 26. Bleeding problems or hemophilia |  |  |  |  |
| 27. Sickle cell anemia |  |  |  |  |
| 28. Hypertension or high blood pressure |  |  |  |  |
| 29. High cholesterol |  |  |  |  |
| 30. Stroke |  |  |  |  |
| 31. Heart attack (coronary) |  |  |  |  |
| 32. Congenital heart defect |  |  |  |  |
| 33. Spina bifida (open spine) |  |  |  |  |
| 34. Anencephaly (underdeveloped brain) |  |  |  |  |
| 35. Scoliosis (spinal curvature) |  |  |  |  |
| 36. Bone deformities or brittleness |  |  |  |  |
| 37. Rheumatoid arthritis |  |  |  |  |
| 38. Osteoarthritis |  |  |  |  |

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| **Medical Condition** | **No** | **Do Not**  **Know** | **If “Yes”, who?**  **(See codes on page 4)** | **Comments; i.e., age at onset, specific diagnosis and treatment.**  **If additional space is needed, attach a separate sheet.** |
| 39. Muscular dystrophy |  |  |  |  |
| 40. Muscle weakness |  |  |  |  |
| 41. Metabolic disorder (cannot eat certain foods) |  |  |  |  |
| 42. Hernia |  |  |  |  |
| 43. Cancer (type, site, age when diagnosed) |  |  |  |  |
| 44. Cystic fibrosis |  |  |  |  |
| 45. Huntington disease |  |  |  |  |
| 46. Multiple sclerosis |  |  |  |  |
| 47. Cerebral palsy |  |  |  |  |
| 48. Neuromuscular disorder; e.g., myasthenia gravis, Lou Gehrig's disease (ALS) |  |  |  |  |
| 49. Alzheimer’s disease or other dementia |  |  |  |  |
| 50. Parkinson's disease |  |  |  |  |
| 51. Seizures, convulsions, epilepsy |  |  |  |  |
| 52. Diabetes (indicate if Type I, Type II) |  |  |  |  |
| 53. Thyroid disorder |  |  |  |  |
| 54. Other hormone disorder |  |  |  |  |
| 55. Dwarfism or short stature |  |  |  |  |
| 56. Tuberculosis |  |  |  |  |
| 57. Respiratory or breathing problems |  |  |  |  |
| 58. Asthma or hay fever |  |  |  |  |
| 59. Allergies – food (specify) |  |  |  |  |
| 60. Allergies – medicine (specify) |  |  |  |  |
| 61. Kidney problems |  |  |  |  |
| 62. Chemical dependency – alcoholism |  |  |  |  |
| 63. Chemical dependency – other drugs (specify) |  |  |  |  |
| 64. Weight problems; e.g., obesity or anorexia |  |  |  |  |
| 65. Stomach problems or ulcers |  |  |  |  |
| 66. Hand abnormalities; e.g., extra / missing / webbed fingers |  |  |  |  |

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| **Medical Condition** | | | **No** | **Do Not**  **Know** | **If “Yes”, who?**  **(See codes on page 4)** | **Comments; i.e., age at onset, specific diagnosis and treatment.**  **If additional space is needed, attach a separate sheet.** | | | |
| 67. Feet abnormalities; e.g., extra / missing / webbed toes | | |  |  |  |  | | | |
| 68. Club foot | | |  |  |  |  | | | |
| 69. Miscarriages – If "Yes", identify by number and cause, if known | | |  |  |  |  | | | |
| 70. Stillbirths – If "Yes", identify by number and cause, if known | | |  |  |  |  | | | |
| 71. Multiple births – Indicate if identical or non-identical | | |  |  |  |  | | | |
| 72. Infertility – Unable to have children | | |  |  |  |  | | | |
| 73. Hepatitis B carrier | | |  |  |  |  | | | |
| 74. Other health problems, conditions or known diagnosis that has not been mentioned | | |  |  |  |  | | | |
| 75. HIV (Human Immunodeficiency Virus) | | |  |  |  |  | | | |
| 76. AIDS (Acquired Immunodeficiency Syndrome) | | |  |  |  |  | | | |
| **SECTION VIII GENETIC TESTING** | | | | | | | | | |
| Yes  No | | Any known genetic testing completed on family member(s). If yes, please state who and describe the results: | | | | | | | |
| **SECTION IX AUTHORIZATION** | | | | | | | | | |
| I authorize the agency assisting in preparing this document to disclose the medical / genetic information in this document to the Circuit Court and the Wisconsin Department of Children and Families for use in preparing and maintaining the medical / genetic history required by law concerning my birth child named in Section I.  I further authorize that the medical / genetic information provided herein may be made available to my birth child, to any future guardians of my birth child, and future caretakers or medical providers for my birth child as permitted by law. This authorization includes information concerning HIV, AIDS, ARC, mental illness, developmental disabilities, and drug and alcohol abuse. | | | | | | | | | |
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|  | **SIGNATURE** – Birth Parent or Provider of Information | | | | | |  | Date Signed |  |

NOTE: In accordance with Wisconsin Statutes, s. 48.425 (1)(am), the following information should accompany this form, at the time of termination of parental rights, if available:

1. A report of any medical examination which either birth parent had within one year before the date of the petition.

2. A report describing the child's prenatal care and medical condition at birth.

3. The medical / genetic history of the child and any other relevant medical / genetic information.