

## 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.

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 BIRTH 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			

	Birth Parent	Your Mother	Your Father
Racial group (Check one)	<input type="checkbox"/> White (not Hispanic) <input type="checkbox"/> Black (not Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No Enrolled Name of Tribe: _____ <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other: _____	<input type="checkbox"/> White (not Hispanic) <input type="checkbox"/> Black (not Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No Enrolled Name of Tribe: _____ <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other: _____	<input type="checkbox"/> White (not Hispanic) <input type="checkbox"/> Black (not Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No Enrolled Name of Tribe: _____ <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ARE YOU ADOPTED?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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.		<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> Female				No. of males: No. of females:	
2.		<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> Female				No. of males: No. of females:	
3.		<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> Female				No. of males: No. of females:	
4.		<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> Female				No. of males: No. of females:	
5.		<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> Female				No. of males: No. of females:	
6.		<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> Female				No. of males: No. of females:	

**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				
Racial group (Check one)	<input type="checkbox"/> White (not Hispanic) <input type="checkbox"/> Black (not Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No Enrolled? Name of Tribe: _____ <hr/> <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other: _____	<input type="checkbox"/> White (not Hispanic) <input type="checkbox"/> Black (not Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No Enrolled? Name of Tribe: _____ <hr/> <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other: _____	<input type="checkbox"/> White (not Hispanic) <input type="checkbox"/> Black (not Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No Enrolled? Name of Tribe: _____ <hr/> <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other: _____	<input type="checkbox"/> White (not Hispanic) <input type="checkbox"/> Black (not Hispanic) <input type="checkbox"/> Hispanic <input type="checkbox"/> Alaskan Native <input type="checkbox"/> American Indian <input type="checkbox"/> Yes <input type="checkbox"/> No Enrolled? Name of Tribe: _____ <hr/> <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other: _____
Education completed. Indicate highest grade or if attended special education.				
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.	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> Female					
2.	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> Female					
3.	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> Female					
4.	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> Female					

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.	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> Female					
6.	<input type="checkbox"/> Full <input type="checkbox"/> Half <input type="checkbox"/> Step	<input type="checkbox"/> Male <input type="checkbox"/> 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.

**CODE IMMEDIATE FAMILY**

BP Birth parent  
 OC Birth parent's other child

**CODE FEMALE RELATIVES**

M Birth parent's mother (child's grandmother)  
 S Birth parent's sister (child's aunt)  
 NE Birth parent's niece (child's cousin)  
 MGM Birth parent's maternal grandmother (your mother's mother)  
 PGM Birth parent's paternal grandmother (your father's mother)  
 OF Other female relative (specify in comments)

**CODE MALE RELATIVES**

F Birth parent's father (child's grandfather)  
 B Birth parent's brother (child's uncle)  
 NEP Birth parent's nephew (child's cousin)  
 MGF Birth parent's maternal grandfather (your mother's father)  
 PGF Birth parent's paternal grandfather (your father's father)  
 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.)	<input type="checkbox"/>	<input type="checkbox"/>		
2. Blindness or other visual problems; e.g., glaucoma, cataracts	<input type="checkbox"/>	<input type="checkbox"/>		
3. Tay-Sachs disease	<input type="checkbox"/>	<input type="checkbox"/>		
4. Deafness, hearing disabilities	<input type="checkbox"/>	<input type="checkbox"/>		
5. Speech problems	<input type="checkbox"/>	<input type="checkbox"/>		
6. Dental problems; e.g., missing or extra teeth	<input type="checkbox"/>	<input type="checkbox"/>		
7. Cleft lip	<input type="checkbox"/>	<input type="checkbox"/>		
8. Cleft palate	<input type="checkbox"/>	<input type="checkbox"/>		
9. Learning disability, dyslexia or other disabilities	<input type="checkbox"/>	<input type="checkbox"/>		
10. Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>		
11. Special education	<input type="checkbox"/>	<input type="checkbox"/>		
12. Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/>	<input type="checkbox"/>		

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	<input type="checkbox"/>	<input type="checkbox"/>		
14. Other chromosomal disorder	<input type="checkbox"/>	<input type="checkbox"/>		
15. Mental illness; e.g., bipolar disorder, schizophrenia, depression	<input type="checkbox"/>	<input type="checkbox"/>		
16. Suicide	<input type="checkbox"/>	<input type="checkbox"/>		
17. Emotional problems	<input type="checkbox"/>	<input type="checkbox"/>		
18. Autism	<input type="checkbox"/>	<input type="checkbox"/>		
19. Frequent headaches; e.g., tension, migraine	<input type="checkbox"/>	<input type="checkbox"/>		
20. Hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>		
21. Microcephalus (small head)	<input type="checkbox"/>	<input type="checkbox"/>		
22. Patches of hair of different color (pigment)	<input type="checkbox"/>	<input type="checkbox"/>		
23. Patches of skin of different color; e.g., pigment or white spots	<input type="checkbox"/>	<input type="checkbox"/>		
24. Birthmarks; e.g., unusual configuration, size, or number	<input type="checkbox"/>	<input type="checkbox"/>		
25. Eczema, acne and other skin problems	<input type="checkbox"/>	<input type="checkbox"/>		
26. Bleeding problems or hemophilia	<input type="checkbox"/>	<input type="checkbox"/>		
27. Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>		
28. Hypertension or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>		
29. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>		
30. Stroke	<input type="checkbox"/>	<input type="checkbox"/>		
31. Heart attack (coronary)	<input type="checkbox"/>	<input type="checkbox"/>		
32. Congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>		
33. Spina bifida (open spine)	<input type="checkbox"/>	<input type="checkbox"/>		
34. Anencephaly (underdeveloped brain)	<input type="checkbox"/>	<input type="checkbox"/>		
35. Scoliosis (spinal curvature)	<input type="checkbox"/>	<input type="checkbox"/>		
36. Bone deformities or brittleness	<input type="checkbox"/>	<input type="checkbox"/>		
37. Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>		
38. Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>		

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	<input type="checkbox"/>	<input type="checkbox"/>		
40. Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>		
41. Metabolic disorder (cannot eat certain foods)	<input type="checkbox"/>	<input type="checkbox"/>		
42. Hernia	<input type="checkbox"/>	<input type="checkbox"/>		
43. Cancer (type, site, age when diagnosed)	<input type="checkbox"/>	<input type="checkbox"/>		
44. Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>		
45. Huntington disease	<input type="checkbox"/>	<input type="checkbox"/>		
46. Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>		
47. Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>		
48. Neuromuscular disorder; e.g., myasthenia gravis, Lou Gehrig's disease (ALS)	<input type="checkbox"/>	<input type="checkbox"/>		
49. Alzheimer's disease or other dementia	<input type="checkbox"/>	<input type="checkbox"/>		
50. Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>		
51. Seizures, convulsions, epilepsy	<input type="checkbox"/>	<input type="checkbox"/>		
52. Diabetes (indicate if Type I, Type II)	<input type="checkbox"/>	<input type="checkbox"/>		
53. Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>		
54. Other hormone disorder	<input type="checkbox"/>	<input type="checkbox"/>		
55. Dwarfism or short stature	<input type="checkbox"/>	<input type="checkbox"/>		
56. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		
57. Respiratory or breathing problems	<input type="checkbox"/>	<input type="checkbox"/>		
58. Asthma or hay fever	<input type="checkbox"/>	<input type="checkbox"/>		
59. Allergies – food (specify)	<input type="checkbox"/>	<input type="checkbox"/>		
60. Allergies – medicine (specify)	<input type="checkbox"/>	<input type="checkbox"/>		
61. Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>		
62. Chemical dependency – alcoholism	<input type="checkbox"/>	<input type="checkbox"/>		
63. Chemical dependency – other drugs (specify)	<input type="checkbox"/>	<input type="checkbox"/>		
64. Weight problems; e.g., obesity or anorexia	<input type="checkbox"/>	<input type="checkbox"/>		
65. Stomach problems or ulcers	<input type="checkbox"/>	<input type="checkbox"/>		
66. Hand abnormalities; e.g., extra / missing / webbed fingers	<input type="checkbox"/>	<input type="checkbox"/>		

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	<input type="checkbox"/>	<input type="checkbox"/>		
68. Club foot	<input type="checkbox"/>	<input type="checkbox"/>		
69. Miscarriages – If "Yes", identify by number and cause, if known	<input type="checkbox"/>	<input type="checkbox"/>		
70. Stillbirths – If "Yes", identify by number and cause, if known	<input type="checkbox"/>	<input type="checkbox"/>		
71. Multiple births – Indicate if identical or non-identical	<input type="checkbox"/>	<input type="checkbox"/>		
72. Infertility – Unable to have children	<input type="checkbox"/>	<input type="checkbox"/>		
73. Hepatitis B carrier	<input type="checkbox"/>	<input type="checkbox"/>		
74. Other health problems, conditions or known diagnosis that has not been mentioned	<input type="checkbox"/>	<input type="checkbox"/>		
75. HIV (Human Immunodeficiency Virus)	<input type="checkbox"/>	<input type="checkbox"/>		
76. AIDS (Acquired Immunodeficiency Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>		

**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.

\_\_\_\_\_  
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.