

## Family History Questionnaire Medical / Genetic – Pregnancy and Delivery Information

**Use of form:** This form is used to collect pregnancy and delivery information for any child whose biological mother has terminated parental rights to that child in Wisconsin. Completion of this form meets the requirements of s.48.425(1)(m), Wis. Stats. Another individual may complete this form on behalf of the 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.

**Instructions:** After completion, this form must be attached to and submitted with the "Family History Questionnaire - Medical / Genetic," form CFS-149. If additional space is needed when completing this form, attach separate sheet(s).

Name – Child (Last, First, Middle)	Birthdate – Child (mm/dd/yyyy)
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### SECTION I PREGNANCY INFORMATION

1. When did you first suspect you were pregnant with this child?	2. When was this pregnancy confirmed by a pregnancy test?
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3.  Yes  No Did you receive prenatal care during this pregnancy? If "Yes", when did prenatal care begin? \_\_\_\_\_

4.  Yes  No Did you gain weight during this pregnancy? If "Yes", number of pounds? \_\_\_\_\_

5.  Yes  No Did you lose weight during this pregnancy? If "Yes", number of pounds? \_\_\_\_\_

6.  Yes  No Were you hospitalized during this pregnancy? If "Yes", list hospitalizations, reasons and dates below.

a. Hospital	Reason(s)	Dates(s) (mm/dd/yyyy)
b. Hospital	Reason(s)	Dates(s)
c. Hospital	Reason(s)	Dates(s)

7.  Yes  No Did you take medication during this pregnancy? (Include prescription and over-the-counter or nonprescription drugs.) If "Yes", list them below.

a. Medication	Purpose of Medication	Date(s) (mm/dd/yyyy)	Dosage Size and Quantity
b. Medication	Purpose of Medication	Date(s)	Dosage Size and Quantity
c. Medication	Purpose of Medication	Date(s)	Dosage Size and Quantity
d. Medication	Purpose of Medication	Date(s)	Dosage Size and Quantity

8.  Yes  No Did you smoke cigarettes during this pregnancy? If "Yes", number per day? \_\_\_\_\_

9.  Yes  No Did anyone in your household smoke during this pregnancy?

10.  Yes  No Were you exposed to unusual fumes or other chemicals during this pregnancy (fumes from workplace, hobbies, etc.)? If "Yes", explain; give examples and dates.

11.  Yes  No Did you consume alcoholic beverages during this pregnancy?

If "Yes", specify what kind of alcohol; i.e., beer, wine, liquor, combination.

Drinking Pattern – Complete for each trimester.	1st Trimester (1 – 3 months)	2nd Trimester (4 – 6 months)	3rd Trimester (7 – 9 months)
<input type="checkbox"/> Binges – Indicate quantity and frequency.			
<input type="checkbox"/> Daily – Indicate quantity.			
<input type="checkbox"/> Other – Occasional; e.g., weekends. Indicate quantity and frequency.			

12.  Yes  No Were you exposed to X-rays during this pregnancy, including dental X-rays? If "Yes", specify when and what body part(s).

13.  Yes  No Were you exposed to other forms of radiation during this pregnancy; e.g., occupational exposure, barium enema / swallow? If "Yes", identify radiation source and dates.

14. During your pregnancy with this child did you have:

**Yes No**

- a. Preeclampsia or hypertension
- b. High blood pressure
- c. Low blood pressure
- d. Albumin or protein in the urine
- e. Diabetes or sugar in your urine
- f. A urinary infection, strange odor or color in your urine
- g. Any vaginal bleeding. If "Yes", specify when and for how long. \_\_\_\_\_
- h. Morning sickness. If "Yes", specify when and for how long. \_\_\_\_\_
- i. Any immunizations during pregnancy or three months before. If "Yes", specify type: \_\_\_\_\_
- j. Any irregular nutrition patterns (special diets). If "Yes", describe: \_\_\_\_\_
- k. Fever. If "Yes", specify how high and duration: \_\_\_\_\_
- l. Unexplained rashes and / or infections. If "Yes", specify when: \_\_\_\_\_
- m. Illness; i.e., chicken pox, mumps, German measles.  
If "Yes", specify illness and when: \_\_\_\_\_
- n. Any allergies? If "Yes", specify: \_\_\_\_\_

15. Your Rh factor is:  Negative  Positive Your blood type is: \_\_\_\_\_

16. The birth father's Rh factor is:  Negative  Positive The birth father's blood type is: \_\_\_\_\_

17. Medical tests administered during this pregnancy. Check "Yes" or "No" if you were tested for the following.

Yes	No	Date of Test	Test Results
<input type="checkbox"/>	<input type="checkbox"/>	VDRL (syphilis)	
<input type="checkbox"/>	<input type="checkbox"/>	Cult / smear (gonorrhea)	
<input type="checkbox"/>	<input type="checkbox"/>	Pap smear	
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis skin test	
<input type="checkbox"/>	<input type="checkbox"/>	Herpes	
Other sexually transmitted disease tests taken – Specify below.			

18. Diagnostic tests administered during this pregnancy. Check "Yes" or "No" if you were tested for the following. If "Yes" provide date of test and test results.

Yes	No	Date of Test	Test Results
<input type="checkbox"/>	<input type="checkbox"/>	Chorionic Villus Sampling	
<input type="checkbox"/>	<input type="checkbox"/>	Amniocentesis	
<input type="checkbox"/>	<input type="checkbox"/>	Other Diagnostic Testing completed	

19.  Yes  No Is this your first pregnancy? If "No", complete the following.

- Number of past pregnancies, including this one \_\_\_\_\_
- Number of live births, including this one \_\_\_\_\_
- Number of miscarriages \_\_\_\_\_  
Cause of miscarriage(s), if known \_\_\_\_\_
- Number of stillbirths \_\_\_\_\_
- Yes  No Were there complications with the other pregnancies?
- Yes  No Are all the previous live-born children currently living? If "No", age(s) of child(ren) at death: \_\_\_\_\_  
Cause of death: \_\_\_\_\_

## SECTION II DELIVERY INFORMATION

- Yes  No Was the delivery vaginal?
- Yes  No Were instruments used to assist the delivery?
- Yes  No Was the delivery by Caesarian section? If "Yes", what complications led to Caesarian? \_\_\_\_\_
- How long was the labor? 1st stage: \_\_\_\_\_ 2nd stage: \_\_\_\_\_ 3rd stage: \_\_\_\_\_
- How soon before birth did the membranes break? \_\_\_\_\_
- Yes  No Did you receive any anesthesia, painkiller or drug to start labor? If "Yes", specify what kind: \_\_\_\_\_
- The child was:  Premature by \_\_\_\_\_ weeks.  Post-mature by \_\_\_\_\_ weeks.
- Yes  No Were there complications with the delivery? If "Yes", specify what kind: \_\_\_\_\_

9. The baby was born:  Feet first (breech)  Head first
10.  Yes  No Was resuscitation or help with breathing required for the child at birth?
11.  Yes  No Was the child jaundiced (yellow) at birth?
12.  Yes  No Was a heart murmur detected at birth?
13.  Yes  No Were any other problems noted AT birth; e.g., any birth defects or handicapping conditions? If "Yes", specify.
14.  Yes  No Were any other problems noted AFTER birth; e.g., any birth defects or handicapping conditions? If "Yes", specify.

15. Consult the hospital record if the data in Item 15 is not known by the parents.

- a. Birth weight \_\_\_\_\_
- b. Birth length \_\_\_\_\_
- c. Head circumference \_\_\_\_\_
- d. APGAR rating: One minute: \_\_\_\_\_ Five minutes: \_\_\_\_\_
- | e. Newborn screening:                              | <u>Positive</u>          | <u>Negative</u>          |  | <u>Positive</u>          | <u>Negative</u>          |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| <input type="checkbox"/> PKU                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Sickle cell anemia                | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Maple syrup urine disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Sickle cell trait                 | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Galactosemia              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Cystic fibrosis                   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hypothyroidism            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Critical congenital heart disease | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hearing loss              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Other disorder – Specify: _____   | <input type="checkbox"/> | <input type="checkbox"/> |

16.  Yes  No Was more than one (1) baby born at this birth? If "Yes":
- a. How many? \_\_\_\_\_
- b. Birth order of this child? \_\_\_\_\_
- c. Condition of other baby(s) born during this birth – Specify.

**NOTE: IF YOU OR THE AGENCY HAVE ADDITIONAL INFORMATION, ADD SEPARATE SHEETS TO ACCOMPANY THIS FORM.**

**SECTION III DISCLOSURE INFORMATION**

I authorize the agency assisting in preparing this document to disclose the medical and genetic information in this document to the Circuit Court and to the Wisconsin Department of Children and Families for use in preparing and maintaining the medical and genetic history required by law concerning my birth child named on page 1.

\_\_\_\_\_  
Name – Birth Mother (Print)

\_\_\_\_\_  
Address – Street, City, State, Zip Code (Print)

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
**SIGNATURE** – Birth Mother

\_\_\_\_\_  
Date Signed (mm/dd/yyyy)

\_\_\_\_\_  
Name – Other Person Providing Information (Print)

\_\_\_\_\_  
Address – Street, City, State, Zip Code (Print)

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
**SIGNATURE** – Other Person Providing Information

\_\_\_\_\_  
Date Signed (mm/dd/yyyy)