DEPARTMENT OF CHILDREN AND FAMILIES
Division of Safety and Permanence

Adoption Records Search Program
PO Box 8916
Madison, WI 53708-8916
(608) 266-7163

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 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			

	Birth Parent	Your Mother	Your Father
Racial group (Check one)	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian ☐ Yes ☐ No Enrolled Name of Tribe: ____ ☐ Asian or Pacific Islander ☐ Other: ____	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian ☐ Yes ☐ No Enrolled Name of Tribe: ____ ☐ Asian or Pacific Islander ☐ Other: ____	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian ☐ Yes ☐ No Enrolled Name of Tribe: ____ ☐ Asian or Pacific Islander ☐ 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:	

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)	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian ☐ Yes ☐ No Enrolled? Name of Tribe: ______ ☐ Asian or Pacific Islander ☐ Other: ______	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian ☐ Yes ☐ No Enrolled? Name of Tribe: ______ ☐ Asian or Pacific Islander ☐ Other: ______	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian ☐ Yes ☐ No Enrolled? Name of Tribe: ______ ☐ Asian or Pacific Islander ☐ Other: ______	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian ☐ Yes ☐ No Enrolled? Name of Tribe: ______ ☐ Asian or Pacific Islander ☐ 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.	☐ Full ☐ Half ☐ Step	☐ Male ☐ Female					
2.	☐ Full ☐ Half ☐ Step	☐ Male ☐ Female					
3.	☐ Full ☐ Half ☐ Step	☐ Male ☐ Female					
4.	☐ Full ☐ Half ☐ Step	☐ Male ☐ 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.	☐ 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.

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.)	☐	☐		
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)	☐	☐		

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	☐	☐		

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	☐	☐		

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.

_____ _____

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.