

**FAMILY HISTORY QUESTIONNAIRE
 MEDICAL / GENETIC – PREGNANCY AND DELIVERY INFORMATION**

USE BLACK INK ONLY

Use of form: This form should be completed by the BIRTH MOTHER. Completion of this form meets the requirements of s. 48.425(1)(am), Wis. Stats. 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		

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

- a. Number of past pregnancies, including this one _____
- b. Number of live births, including this one _____
- c. Number of abortions _____
- d. Number of miscarriages _____
 Cause of miscarriage(s), if known _____
- e. Number of stillbirths _____
- f. Yes No Were there complications with the other pregnancies?
- g. 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

- 1. Yes No Was the delivery vaginal?
- 2. Yes No Were instruments used to assist the delivery?
- 3. Yes No Was the delivery by Caesarian section? If "Yes", what complications led to Caesarian? _____
- 4. How long was the labor? 1st stage: _____ 2nd stage: _____ 3rd stage: _____
- 5. How soon before birth did the membranes break? _____
- 6. Yes No Did you receive any anesthesia, painkiller or drug to start labor? If "Yes", specify what kind: _____

7. The child was: Premature by _____ weeks. Post-mature by _____ weeks.
8. 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. New born 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"/> 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)