STATE OF WISCONSIN, CIRCUIT COURT, _____ COUNTY

Petitioner: _____

-VS-

Respondent: _____

Family Medical History Questionnaire

Case No. _____

(Parent with sole legal custody completes this section only.) The children subject to the custody order in this case are:

Name	Date of Birth	Name and Address of Child's Primary Physician

Parent without legal custody must complete the following medical history questionnaire. The purpose is to record any known medical conditions and medical history information that may affect your child(ren). This information can then be used to diagnose and treat your child(ren) in the future if that becomes necessary. The information must be specific as to you, your parents, your brothers and sisters, and the brothers or sisters of any child(ren) subject to this Order.

This is a confidential medical history document:

The physician or health care provider will retain and release the information in a confidential manner in accordance with statutory requirements.

This information is needed for the possible health and safety of your child! Please be accurate and complete.

Medical Condition	No	Do Not Know	Yes	Comments: Who (what is the relationship of the person with the condition to the child; for example, mother, maternal aunt, paternal grandfather, etc.), when did it occur, specific diagnoses and treatment (attach extra explanation, if needed)
1. Visual problems, glaucoma, lazy eye, cataracts, blindness	☐	☐	☐	
2. Hearing problems, deafness, speech problems	☐	☐	☐	
3. Dental problems, extra or missing teeth, cleft palate or lip	☐	☐	☐	
4. Learning or emotional disability, intellectual disability, attention deficit disorder	☐	☐	☐	
5. Mental illness, depression, mania	☐	☐	☐	
6. Frequent headaches (tension, migraine), hydrocephalus	☐	☐	☐	
7. Skin problems, birthmarks, eczema, acne, different colored patches of hair or skin	☐	☐	☐	
8. Bleeding problems, hemophilia, sickle cell anemia	☐	☐	☐	
9. Heart attack, stroke, high blood pressure	☐	☐	☐	
10. Bone defect, open spine, spinal curvature, arthritis	☐	☐	☐	

11. Muscle weakness, hernias	☐	☐	☐	
Medical Condition	No	Do Not Know	Yes	Comments: Who (what is the relationship of the person with the condition to the child; for example, mother, maternal aunt, paternal grandfather, etc.), when did it occur, specific diagnoses and treatment (attach extra explanation, if needed)
12. Cancer (type, site, age)	☐	☐	☐	
13. Birth defects: Downs, Cystic Fibrosis, Huntington's Chorea, cerebral palsy, muscular dystrophy, others	☐	☐	☐	
14. Nerve-muscle disorder, multiple sclerosis, myasthenia gravis	☐	☐	☐	
15. Seizure disorder	☐	☐	☐	
16 Diabetes (juvenile or adult, insulin or noninsulin)	☐	☐	☐	
17. Thyroid disorder, other hormone disorder, dwarfism	☐	☐	☐	
18. Breathing problems, asthma, emphysema, tuberculosis, allergies	☐	☐	☐	
19. Medical or food allergies	☐	☐	☐	
20. Kidney or liver problems, hepatitis B or C carrier	☐	☐	☐	
21. Chemical dependency - alcohol, tobacco, other substances	☐	☐	☐	
22. Stomach problems, ulcer, reflux	☐	☐	☐	
23. Weight problems, obesity, anorexia	☐	☐	☐	
24. Hand or feet abnormalities, club foot, webbed, extra or missing fingers or toes	☐	☐	☐	
25. Miscarriages or stillbirths (number and cause, if known)	☐	☐	☐	
26. Multiple births (identical or nonidentical), infertility	☐	☐	☐	
27. HIV infection (only if parent of child)	☐	☐	☐	
28. AIDS (only if parent of child)	☐	☐	☐	
29. Other health problems or concerns	☐	☐	☐	

30. During the past year

☐ I have not had a medical examination.

☐ I have had a medical examination. Explain when, by whom, for what complaints, results of exam, medications or other treatment and present status or condition: _____

I certify that the information provided is true, correct and complete to the best of my knowledge, information and belief.

▶ _____
Signature

_____
Name Printed or Typed

_____
Address

_____
Email Address Telephone Number

_____
Date State Bar No. (if any)