STATE OF WISCONSIN CIRCUIT COURT ______________________ COUNTY

Petitioner: ______________________________

-vs-

Respondent: ______________________________

FAMILY MEDICAL HISTORY QUESTIONNAIRE

Case No. ____________________

(To be completed by custodial parent.) Name and address of child's primary physician:

Any parent who is not awarded custody must complete this medical history questionnaire. The purpose is to record any known medical and medical history information that may affect your child. This information can then be used to diagnose and treat your child 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 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, mental retardation, 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				
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				

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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)
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____

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I certify that the information provided is true, correct and complete to the best of my knowledge, information and belief. The children subject to the custody order in this case are:

Name	Date of Birth

Name	Date of Birth

____
Signature

____
Name

____
Date