

*Please print or type*

Petitioner: \_\_\_\_\_

**Family Medical  
History Questionnaire**

-VS-

Respondent: \_\_\_\_\_

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Hearing problems, deafness, speech problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Dental problems, extra or missing teeth, cleft palate or lip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Learning or emotional disability, mental retardation, attention deficit disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Mental illness, depression, mania	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Frequent headaches (tension, migraine), hydrocephalus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Skin problems, birthmarks, eczema, acne, different colored patches of hair or skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
8. Bleeding problems, hemophilia, sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
9. Heart attack, stroke, high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
10. Bone defect, open spine, spinal curvature, arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Muscle weakness, hernias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Birth defects: Downs, Cystic Fibrosis, Huntington's Chorea, cerebral palsy, muscular dystrophy, others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Nerve-muscle disorder, multiple sclerosis, myasthenia gravis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Diabetes (juvenile or adult, insulin or noninsulin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Thyroid disorder, other hormone disorder, dwarfism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Breathing problems, asthma, emphysema, tuberculosis, allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Medical or food allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Kidney or liver problems, hepatitis B or C carrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Chemical dependency - alcohol, tobacco, other substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Stomach problems, ulcer, reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. Weight problems, obesity, anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Hand or feet abnormalities, club foot, webbed, extra or missing fingers or toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. Miscarriages or stillbirths (number and cause, if known)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
26. Multiple births (identical or nonidentical), infertility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27. HIV infection (only if parent of child)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28. AIDS (only if parent of child)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
29. Other health problems or concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

\_\_\_\_\_ Date