DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01063 (08/2017)

STATE OF WISCONSIN

HEALTHCHECK FAMILY HISTORY

RESET FORM

INSTRUCTIONS: Please list all family members, natural or blood relatives, living or dead, with present or past illnesses, disabilities, or conditions. For each person, check those that apply. Use space below to indicate other illnesses, disabilities, conditions, or any other significant information.

Name of Member

Birth Year of Family Member/Blood Relative												
Present or Past Illness	Natural Father	Natural Mother										Any of the Grandparents
AUTISM	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALCOHOLISM (Drinking Problem)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ALLERGIES OR ASTHMA	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
BEHAVIORAL DIFFICULTIES	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
BIRTH DEFECTS	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
EPILEPSY	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
HEARING DISABILITIES	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
HEART ATTACK UNDER AGE 40	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIGH BLOOD CHOLESTEROL	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
INTELLECTUAL DISABILITY	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LEARNING DIFFICULTIES	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NEED FOR SPECIAL EDUCATION	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
SPEECH AND LANGUAGE PROBLEMS	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
VISION DIFFICULTIES	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
IF DECEASED, AGE AT DEATH												
IF DECEASED, CAUSE OF DEATH												

Any other illnesses, disabilities, or conditions that run in your family that you are concerned about?

Any other significant information?