Family Medical History Questionnaire

This form is used to collect family medical history from newly discovered genetic relatives. You can also use this form to update medical history information.

SECTION I THE PERSON SEEKING INFORMATION ABOUT THEIR FAMILY MEDICAL HISTORY

Name – (Last, First, Middle)	Birthdate (mm/dd/yyyy)
Address – Current (Street, City, State, Zip Code)	Telephone Number
Place of Birth (City, State, Country) - if known	Email Address

SECTION II NEW FAMILY MEMBER: DESCRIBE YOUR BACKGROUND AND YOUR PARENTS

	YOU	Your Mother	Your Father
Name (Last, First, Middle)			
Place of Birth/Nationality			
Birthdate (mm/dd/yyyy)			
Height and weight			
Ethnic group (Check one)	☐ European ☐ African ☐ Hispanic ☐ Native: _____ ☐ American Indian ☐ Yes ☐ No Enrolled Name of Tribe: _____ ☐ Asian or Pacific Islander ☐ Mixed 2 or more ☐ Other: _____	☐ European ☐ African ☐ Hispanic ☐ Native ☐ American Indian ☐ Yes ☐ No Enrolled Name of Tribe: _____ ☐ Asian or Pacific Islander ☐ Mixed 2 or more ☐ Other: _____	☐ White (not Hispanic) ☐ Black (not Hispanic) ☐ Hispanic ☐ Alaskan Native ☐ American Indian ☐ Yes ☐ No Enrolled Name of Tribe: _____ ☐ Asian or Pacific Islander ☐ Mixed 2 or more ☐ Other: _____
Occupation			
Education completed. Indicate highest grade or if attended special education classes.			
If deceased, age at death and cause of death, if known.			
Are you of Jewish descent?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Adopted?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Donor conceived?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Is paternity unknown?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SECTION III NEW FAMILY MEMBER: DESCRIBE YOUR OTHER CHILDREN

List in order of birth. Include pregnancy losses, stillbirths, and miscarriages. If deceased, indicate age at death and cause, if known.
If additional space is needed, attach separate sheets.

Name (Last, First, Middle)	Relationship To Person Requesting Info	Gender	Birthdate	Height	Weight	Health / Medical Problems	If Deceased, Cause and Age at Death, if Known
1.	☐ Full ☐ Half ☐ Step	☐ Male ☐ Female ☐ Other					
2.	☐ Full ☐ Half ☐ Step	☐ Male ☐ Female ☐ Other					
3.	☐ Full ☐ Half ☐ Step	☐ Male ☐ Female ☐ Other					
4.	☐ Full ☐ Half ☐ Step	☐ Male ☐ Female ☐ Other					

SECTION IV NEW FAMILY MEMBER: DESCRIBE YOUR BROTHERS AND SISTERS

If additional space is needed, attach separate sheet.

Name – Current (Last, First, Middle)	Maiden	Relationship	Gender	Birthdate	Height	Weight	Sibling's Children	If Deceased, Cause and Age at Death, if Known
1.		☐ Full ☐ Half ☐ Step	☐ Male ☐ Female ☐ Other				No of males: No of females: Other:	
2.		☐ Full ☐ Half ☐ Step	☐ Male ☐ Female ☐ Other				No of males: No of females: Other:	
3.		☐ Full ☐ Half ☐ Step	☐ Male ☐ Female ☐ Other				No of males: No of females: Other:	
4.		☐ Full ☐ Half ☐ Step	☐ Male ☐ Female ☐ Other				No of males: No of females: Other:	
5.		☐ Full ☐ Half ☐ Step	☐ Male ☐ Female ☐ Other				No of males: No of females: Other:	
6.		☐ Full ☐ Half ☐ Step	☐ Male ☐ Female ☐ Other				No of males: No of females: Other:	

SECTION V NEW FAMILY MEMBER: DESCRIBE YOUR GRANDPARENTS

Category	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Name – Current (Last, First, Middle)				
Height and weight				
National Background				
Ethnic group (Check one)	☐ European ☐ African ☐ Hispanic ☐ Native ☐ American Indian ☐ Yes ☐ No Enrolled? Name of Tribe: ________ ☐ Asian or Pacific Islander ☐ Mixed 2 or more ☐ Other: ________	☐ European ☐ African ☐ Hispanic ☐ Native ☐ American Indian ☐ Yes ☐ No Enrolled? Name of Tribe: ________ ☐ Asian or Pacific Islander ☐ Mixed 2 or more ☐ Other: ________	☐ European ☐ African ☐ Hispanic ☐ Native ☐ American Indian ☐ Yes ☐ No Enrolled? Name of Tribe: ________ ☐ Asian or Pacific Islander ☐ Mixed 2 or more ☐ Other: ________	☐ European ☐ African ☐ Hispanic ☐ Native ☐ American Indian ☐ Yes ☐ No Enrolled? Name of Tribe: ________ ☐ Asian or Pacific Islander ☐ Mixed 2 or more ☐ Other: ________
Education completed. Indicate highest grade or if attended special education.				
If deceased, age at death and cause of death, if known.				

SECTION VI NARRATION — FAMILY SOCIAL HISTORY

SECTION VII NEW FAMILY MEMBER MEDICAL HISTORY

Indicate by checking "Yes" or "No" if you or any blood relatives ever had or now have the medical conditions listed. Complete the "Comments" section, indicating age when condition began and specific diagnosis and treatment; indicate if 'UNKNOWN". Indicate all relatives in terms of their relationship to you as listed in the following code section.

CODE	IMMEDIATE FAMILY
OC	your other child(ren)

CODE	FEMALE RELATIVES
M	your mother
S	your sister
NE	your niece
MGM	your mother's mother (maternal grandmother)
PGM	your father's mother (paternal grandmother)
OF	other female relative (specify in comments)

CODE	MALE RELATIVES
F	your father
B	your brother
NEP	your nephew
MGF	your mother's father (maternal grandfather)
PGF	your father's father (paternal grandfather)
OM	other male relative (specify in comments)

Medical Condition	No	Do Not Know	If "Yes", who? (See codes above)	Comments; i.e., age at onset, specific diagnosis and treatment. If additional space is needed, attach a separate sheet.
1. Glasses (near / farsighted, cross-eyed, astigmatic, etc.)	☐	☐		
2. Blindness or other visual problems; e.g., glaucoma, cataracts	☐	☐		
3. Tay-Sachs disease	☐	☐		
4. Deafness, hearing disabilities	☐	☐		
5. Speech problems	☐	☐		
6. Dental problems; e.g., missing or extra teeth	☐	☐		
7. Cleft lip	☐	☐		
8. Cleft palate	☐	☐		
9. Learning disability, dyslexia or other disabilities	☐	☐		
10. Mental retardation	☐	☐		
11. Special education	☐	☐		
12. Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD)	☐	☐		
13. Down syndrome	☐	☐		
14. Other chromosomal disorder	☐	☐		
15. Mental illness; e.g., bipolar disorder, schizophrenia, depression	☐	☐		
16. Suicide	☐	☐		
17. Emotional problems	☐	☐		
18. Autism	☐	☐		
19. Frequent headaches; e.g., tension, migraine	☐	☐		
20. Hydrocephalus	☐	☐		

Medical Condition	No	Do Not Know	If "Yes", who? (See codes on page 4)	Comments; i.e., age at onset, specific diagnosis and treatment. If additional space is needed, attach a separate sheet.
21. Microcephalus (small head)	☐	☐		
22. Patches of hair of different color (pigment)	☐	☐		
23. Patches of skin of different color; e.g., pigment or white spots	☐	☐		
24. Birthmarks; e.g., unusual configuration, size, or number	☐	☐		
25. Eczema, acne and other skin problems	☐	☐		
26. Bleeding problems or hemophilia	☐	☐		
27. Sickle cell anemia	☐	☐		
28. Hypertension or high blood pressure	☐	☐		
29. High cholesterol	☐	☐		
30. Stroke	☐	☐		
31. Heart attack (coronary)	☐	☐		
32. Congenital heart defect	☐	☐		
33. Spina bifida (open spine)	☐	☐		
34. Anencephaly (underdeveloped brain)	☐	☐		
35. Scoliosis (spinal curvature)	☐	☐		
36. Bone deformities or brittleness	☐	☐		
37. Rheumatoid arthritis	☐	☐		
38. Osteoarthritis	☐	☐		
39. Muscular dystrophy	☐	☐		
40. Muscle weakness	☐	☐		
41. Metabolic disorder (cannot eat certain foods)	☐	☐		
42. Hernia	☐	☐		
43. Cancer (type, site, age when diagnosed)	☐	☐		
44. Cystic fibrosis	☐	☐		
45. Huntington disease	☐	☐		
46. Multiple sclerosis	☐	☐		
47. Cerebral palsy	☐	☐		
48. Neuromuscular disorder; ie myasthenia gravis, Lou Gehrig's disease (ALS)	☐	☐		
49. Alzheimer's disease or other dementia	☐	☐		
50. Parkinson's disease	☐	☐		

Medical Condition	No	Do Not Know	If "Yes", who? (See codes on page 4)	Comments; i.e., age at onset, specific diagnosis and treatment. If additional space is needed, attach a separate sheet.
51. Seizures, convulsions, epilepsy	☐	☐		
52. Diabetes (indicate if Type I, Type II)	☐	☐		
53. Thyroid disorder	☐	☐		
54. Other hormone disorder	☐	☐		
55. Dwarfism or short stature	☐	☐		
56. Tuberculosis	☐	☐		
57. Respiratory or breathing problems	☐	☐		
58. Asthma or hay fever	☐	☐		
59. Allergies – food (specify)	☐	☐		
60. Allergies – medicine (specify)	☐	☐		
61. Kidney problems	☐	☐		
62. Chemical dependency – alcoholism	☐	☐		
63. Chemical dependency – other drugs (specify)	☐	☐		
64. Weight problems (ie obesity or anorexia)	☐	☐		
65. Stomach problems or ulcers	☐	☐		
66. Hand abnormalities; e.g., extra / missing / webbed fingers	☐	☐		
67. Feet abnormalities; e.g., extra / missing / webbed toes	☐	☐		
68. Club foot	☐	☐		
69. Miscarriages – If "Yes", identify by number and cause, if known	☐	☐		
70. Stillbirths – If "Yes", identify by number and cause, if known	☐	☐		
71. Multiple births – Indicate if identical or non-identical	☐	☐		
72. Infertility – Unable to have children	☐	☐		
73. Hepatitis B carrier	☐	☐		
74. Other health problems, conditions or known diagnosis not yet mentioned	☐	☐		
75. HIV (Human Immunodeficiency Virus)	☐	☐		
76. AIDS (Acquired Immunodeficiency Syndrome)	☐	☐		

SECTION VIII GENETIC TESTING

☐ Yes ☐ No Any known medical genetic testing completed on family member(s). If yes, please state who and describe the results: