LABEL

Family History Questionnaire

Patient's Name_____

Date of Birth _____

Mother's Name _____

Father's Name _____

For office use only:

MRN _____

Family #

Please complete this form to the best of your knowledge and bring it to your Genetics appointment. This information will not be released to outside parties without a signed consent from the patient or guardian.

Please check if any family members have the following:

_____ the same condition as the patient we are seeing
_____ mental retardation, developmental delays, or learning disabilities
_____ birth defect(s) (i.e. cleft lip and/or palate, congenital heart defect, spina bifida, etc.)
_____ lost more than two pregnancies
_____ a stillborn child or a child who has died in the first several years of life
_____ other conditions that may be inherited (i.e. deafness, psychiatric illness, seizure disorder, blindness, bone disorder, muscular dystrophy, chromosome disorder, etc.)

If yes, please indicate which family member(s) and describe in the appropriate section that follows. If you need more room, there is additional space on the last page, or you may add additional pages.

Family History I: Patient

List the patient's major health concerns:

_____
_____
_____

Patient's Brothers and Sisters

Name	Full*, half, adopted?	Sex M/F	DOB or Age	Living? Y/N	Medical or Learning Problems or Age and Cause of Death	Mother's Name	Father's Name

Patient's Children, if applicable (please note if any children are adopted)

Name	Sex M/F	DOB or Age	Living? Y/N	Medical or Learning Problems or Age and Cause of Death	Name of other parent
Pregnancy losses?	Y/N	How many?	Weeks along?	Reason for loss?	

* Full brothers/sisters are those with the same biological mother and father. Half-brothers/sisters have only one biological parent in common. Biological family members are those which share a common relative (as opposed to those related by marriage).

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Family History II: Patient's Mother

Mother's Name_____ Maiden Name_____
Date of Birth_____ Living? _____ Occupation_____
Medical or Learning Problems_____
Date and Cause of Death (if applicable)_____
Ethnicity/Ancestors' Country of Origin_____
Number of Pregnancies_____ Number of Children_____ All Children with the Same Partner? _____
Any pregnancy losses?_____ Reason for losses_____ Weeks along_____

Mother's Parents

Name	Sex M/F	DOB/ Age	Living? Y/N	Medical or Learning Problems or Age and Cause of Death

Mother's Brothers and Sisters

Name	Full*, half, Adopted?	Sex M/F	DOB or Age	Living? Y/N	Medical or Learning Problems or Age and Cause of Death	Mother's Name	Father's Name

Mother's Nieces and Nephews (please note if any are adopted)

Name	Sex M/F	DOB/ Age	Living? Y/N	Medical or Learning Problems or Age and Cause of Death	Mother's Name	Father's Name

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Family History III: Father

Father's Name_____
Date of Birth_____ Living? _____ Occupation_____
Medical or Learning Problems_____
Date and Cause of Death (if applicable)_____
Ethnicity/Ancestors' Country of Origin_____
Number of Children_____ All Children with the Same Partner? _____

Father's Parents

Name	Sex M/F	DOB/ Age	Living? Y/N	Medical or Learning Problems or Age and Cause of Death

Father's Brothers and Sisters

Name	Full*, half, Adopted?	Sex M/F	DOB/ Age	Living? Y/N	Medical or Learning Problems or Age and Cause of Death	Mother's Name	Father's Name

Father's Nieces and Nephews (please note if any are adopted)

Name	Sex M/F	DOB/ Age	Living? Y/N	Medical or Learning Problems or Age and Cause of Death	Mother's Name	Father's Name

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Other biological family members, not listed above, with medical or learning problems about which you are concerned

Name	Sex M/F	DOB/ Age	Living? Y/N	Medical or Learning Problems or Age and Cause of Death	Mother's Name	Father's Name	Relationship to Patient

Has anyone else in the family been evaluated by Medical Genetics at Riley Hospital or Indiana University? (if yes, please explain)_____

_____

_____

Please note that written consent from the above individual(s), or their guardians, will be required for us to review and discuss these family records with you.

Please tell us what you hope to learn from your visit with Medical Genetics:

_____

_____

_____

_____

Thank you very much for taking the time to complete this questionnaire. This information will assist us in our evaluation and enable us to provide the best possible care for you and your family.

Sincerely,

The Medical Genetics Staff

Person Completing this Form _____

Relationship to Patient_____Date_____

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