

FAMILY HISTORY QUESTIONNAIRE

This family history questionnaire needs to be completed so that we can provide you with the most accurate information and address your questions and concerns. Please fax or mail your completed questionnaire to us at least **2 weeks** prior to your appointment.

- Information should be provided on biological relatives only
Do not provide information about adopted, foster or step-relatives.
- Indicate half-brothers and half-sisters with an asterisk (*) by their name
Indicate maternal half-brothers and half-sisters (same mother, different father) with *M
Indicate paternal half-brothers and half-sisters (same father, different mother) with *P
- If exact age is not known, approximate:
(e.g. early 40's, late 60's)
- If requested information is not known, write "unknown."
- If additional space is needed, please attach another sheet of paper and indicate which question is being addressed.

We understand that some of this information about your family may not be available to you and encourage you to contact other relatives and provide what information you can.

MEDICAL RECORDS

If you have a genetic condition or are being seen in our clinic to rule out a genetic condition, you need to have your medical records sent or faxed to our office at least **one week** prior to your appointment. Review of your medical records is important for providing you with a thorough evaluation. If it is not possible for records to be sent to us in advance, please bring copies that we can keep to your appointment. An additional appointment may be needed, if medical records are not sent to us in advance, to allow us time to review them and discuss their implications with you.

If you are being seen in our clinic because of a family history of a genetic condition, please try to obtain medical records on affected family members so that we may review their records and confirm their diagnosis. This is important for providing you with an accurate risk assessment. A medical records release form is enclosed which can be xeroxed and given to relatives with a genetic condition or their next of kin to complete.

SENDING YOUR COMPLETED QUESTIONNAIRE

You may wish to xerox your completed questionnaire prior to sending it to have a copy for your records. If we do not receive your questionnaire **two weeks** prior to your appointment, your appointment may need to be rescheduled or an additional appointment may be needed to collect and review family history information. If you have any questions, please do not hesitate to contact us. Please fax or mail your completed questionnaire to:

**Division of Medical Genetics
University of Michigan
300 N. Ingalls, NI3 A03
Ann Arbor, MI 48109-0419
Phone: (734) 763-2532
Fax: (734) 763-7672**

**For further information regarding our clinic, please visit our website located at
<http://www.umich.edu/~mmgmed/clinic/medical/index.htm>.**

Name: _____ Date: _____ Appt. Date: _____

Date of Birth: _____ Occupation: _____

Highest level of education completed: _____

Your physician/referring physician:

Name: _____

Address: _____

Phone: (_____) _____

Did this physician refer you to our clinic? YES__ NO__

Are you adopted? _____ YES _____ NO

If YES, do you know family/medical history information about either of your biological parents? _____ YES _____NO

If YES, please complete the family history form with this information.

Are any of your relatives adopted? ___ YES ___ NO

If YES, indicate name(s) and relationship to you: _____

Name: _____

Address: _____

Phone: (_____) _____

Did this physician refer you to our clinic? YES__ NO__

Indicate whether you or any of your relatives have a family history of any of the following*: (Circle Y-Yes; N-No)

- | | |
|--|---|
| 1. Y N Birth defects (e.g. cleft lip, club foot) | 16. Y N Muscle disease |
| 2. Y N Bleeding disorders (e.g. Hemophilia) | 17. Y N Neurofibromatosis |
| 3. Y N Blindness/Eye abnormality | 18. Y N Neurologic disorder |
| 4. Y N Connective tissue disorders (e.g. Marfan syndrome, Ehlers-Danlos syndrome, Osteogenesis Imperfecta) | 19. Y N Psychiatric disorder (e.g. schizophrenia, manic-depression) |
| 5. Y N Deafness | 20. Y N Respiratory disorder/cystic fibrosis |
| 6. Y N Diabetes | 21. Y N Seizures/Epilepsy |
| 7. Y N Down syndrome | 22. Y N Severe anemia/sickle cell anemia/thalassemia |
| 8. Y N Early onset (<65 years old) Alzheimer's | 23. Y N Skeletal disorders/short stature |
| 9. Y N Early onset (<50 years old) Cancer | 24. Y N Skin disorder |
| 10. Y N Early onset (<50 years old) Emphysema | 25. Y N Spina bifida/hydrocephaly |
| 11. Y N Early onset (<50 years old) Heart disease | 26. Y N Stillbirths/children who died young |
| 12. Y N Fragile X syndrome | 27. Y N Pregnancy losses (individual w/more than 2) |
| 13. Y N Kidney disease | 28. Y N Chromosome abnormality, other |
| 14. Y N Mental retardation | 29. Y N Other inherited/genetic condition(s) |
| 15. Y N Metabolic disorders (e.g. PKU, Tay-Sachs) | _____ |

*If you circled "YES" to any of the above conditions, be sure to list the condition(s) in the "Significant Medical Conditions" column when completing the following pages about your relatives.

RELATIVES WITH A GENETIC CONDITION

If YOU have a genetic condition, please include your name and information here and write "self" in "relationship to you" column.

FULL NAME (First, Last, Maiden)	M-Male F-Female (circle)	L-Living D-Deceased (circle)	Age Birthdate (If known)	Age at Death (Date if known)	Relationship to You (e.g. mother's sister, father's brother's son)	Genetic Condition	Age at Diagnosis	Seen at U of M?
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No

Have you or any of your relatives with a genetic condition had genetic testing? _____ YES _____ NO

If YES, please try to obtain a copy of the report and provide this information:

<u>Name</u>	<u>Laboratory that Performed Testing</u>	<u>Result</u>
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YOUR CHILDREN

If you do not have any children, check here ____.

YOUR CHILDRENS' CHILDREN

FULL NAME (First, Last, Maiden)	M-Male F-Female (circle)	L-Living D-Deceased (circle)	Age Birthdate (Date if known)	Age at Death (Date if known)	Significant Medical Conditions Cause of Death (If deceased)	LIVING CHILDREN	DECEASED CHILDREN
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____
	M F	L D				# of sons: __ Ages: _____ # of daughters: __ Ages: _____	# of sons: __ Ages: _____ # of daughters: __ Ages: _____

Have any of the family members listed above had pregnancy losses? _____ YES _____ NO _____ DO NOT KNOW

Name	Number of miscarriages	Number of weeks pregnant when each loss occurred	Number of stillbirths	Number of weeks pregnant when each loss occurred

YOUR MOTHER'S FAMILY

Your mother's family's countries of origin (i.e. Irish, Chinese, English): _____ Are you Jewish? _____ YES _____ NO

Have related family members (e.g. first cousins) married each other? YES _____ NO _____

If YES, provide names and their relationship to each other:

	FULL NAME (First, Last, Maiden)	M-Male F-Female (circle)	L-Living D-Deceased (circle)	Age Birthdate (If known)	Age at Death (Date if known)	Significant Medical Conditions Cause of Death (If deceased)	LIVING CHILDREN	DECEASED CHILDREN
Your Mother		M F	L D					
Your Mother's Mother		M F	L D					
Your Mother's Father		M F	L D					
Your Mother's Brothers and Sisters		M F	L D				# of sons: _____ # of daughters: _____	# of sons: _____ # of daughters: _____
		M F	L D				# of sons: _____ # of daughters: _____	# of sons: _____ # of daughters: _____
		M F	L D				# of sons: _____ # of daughters: _____	# of sons: _____ # of daughters: _____
If your mother has no brothers or sisters, check here _____.		M F	L D				# of sons: _____ # of daughters: _____	# of sons: _____ # of daughters: _____
		M F	L D				# of sons: _____ # of daughters: _____	# of sons: _____ # of daughters: _____
		M F	L D				# of sons: _____ # of daughters: _____	# of sons: _____ # of daughters: _____
		M F	L D				# of sons: _____ # of daughters: _____	# of sons: _____ # of daughters: _____
		M F	L D				# of sons: _____ # of daughters: _____	# of sons: _____ # of daughters: _____

Have any of the family members listed above had pregnancy losses? _____ YES _____ NO _____ DO NOT KNOW

Name	Number of miscarriages	Number of weeks pregnant when each loss occurred	Number of stillbirths	Number of weeks pregnant when each loss occurred

YOUR FATHER'S FAMILY

Your father's family's countries of origin (i.e. Irish, Chinese, English): _____ Are you Jewish? _____ YES _____ NO

Have related family members (e.g. first cousins) married each other? YES _____ NO _____

If YES, provide names and their relationship to each other:

	FULL NAME (First, Last, Maiden)	M-Male F-Female (circle)	L-Living D-Deceased (circle)	Age Birthdate (If known)	Age at Death (Date if known)	Significant Medical Conditions Cause of Death (If deceased)	LIVING CHILDREN	DECEASED CHILDREN
Your Father		M F	L D					
Your Father's Mother		M F	L D					
Your Father's Father		M F	L D					
Your Father's Brothers and Sisters If your father has no brothers or sisters, check here ____.		M F	L D				# of sons: ____ # of daughters: ____	# of sons: ____ # of daughters: ____
		M F	L D				# of sons: ____ # of daughters: ____	# of sons: ____ # of daughters: ____
		M F	L D				# of sons: ____ # of daughters: ____	# of sons: ____ # of daughters: ____
		M F	L D				# of sons: ____ # of daughters: ____	# of sons: ____ # of daughters: ____
		M F	L D				# of sons: ____ # of daughters: ____	# of sons: ____ # of daughters: ____
		M F	L D				# of sons: ____ # of daughters: ____	# of sons: ____ # of daughters: ____
		M F	L D				# of sons: ____ # of daughters: ____	# of sons: ____ # of daughters: ____
		M F	L D				# of sons: ____ # of daughters: ____	# of sons: ____ # of daughters: ____

Have any of the family members listed above had pregnancy losses? _____ YES _____ NO _____ DO NOT KNOW

Name	Number of miscarriages	Number of weeks pregnant when each loss occurred	Number of stillbirths	Number of weeks pregnant when each loss occurred

If you have children, complete this information on their other parent (your wife/husband/partner). Duplicate this page if your children have different parents.

Name of your children's other parent: _____ Birthdate/Age: _____

Does this parent have a family history of birth defects/mental retardation/genetic disorder/cancer/pregnancy losses? YES ____ NO ____

RELATIVES WITH A GENETIC CONDITION

If this parent has a genetic condition, please include their name and information here and write "parent" in "relationship" column.

FULL NAME (First, Last, Maiden)	M-Male F-Female (circle)	L-Living D-Deceased (circle)	Age Birthdate (If known)	Age at Death (Date if known)	Relationship (e.g. mother's sister, father's brother's son)	Genetic Condition/Pregnancy Losses	Age at Diagnosis	Seen at U of M?
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No
	M F	L D						__ Yes __ No

Have any of these relatives with a genetic condition had genetic testing? ____ YES ____ NO

If YES, please try to obtain a copy of the report and provide this information:

<u>Name</u>	<u>Laboratory that Performed Testing</u>	<u>Result</u>

1. Have you had any surgeries or hospitalizations for a medical condition? YES NO

<u>Medical Condition</u>	<u>Year</u>	<u>Type of surgery</u>

2. Do you have any medical condition(s) that have required monitoring or treatment? (e.g. high blood pressure, asthma, diabetes, depression)? YES NO

<u>Medical condition</u>	<u>Age at diagnosis</u>	<u>Treatment</u>

3. Are you currently taking any medications? YES NO

<u>Name of medication</u>	<u>Dose</u>	<u>Date started taking medication</u>

4. What are the main questions or concerns that you would like addressed during your appointment in the Medical
5. Genetics Clinic?

6. Indicate if other family members will be coming with you to your appointment:

<u>Name</u>	<u>Age</u>	<u>Relationship to You</u>

7. How did you FIRST find out about our clinic (Check only ONE)?

<input type="checkbox"/> Physician	<input type="checkbox"/> Newspaper article
<input type="checkbox"/> Friend/Relative	<input type="checkbox"/> Magazine article
<input type="checkbox"/> Obtained phone number for the University of Michigan and called	<input type="checkbox"/> University of Michigan publication
<input type="checkbox"/> Other _____	<input type="checkbox"/> Television program

Thank you for taking the time to complete this family history questionnaire. If there is other information about your family history that is not addressed in this questionnaire, please include on a separate sheet of paper.