London Health Sciences Centre

*Medical Genetics Program of Southwestern Ontario*

John McGivney Children's Centre

**Tel: 519-252-7281 Ext 350**
**Fax: 519-977-2216**

**Please note the following:**

- Please complete the information requested as completely as possible. All questions are in relation to the person referred to our clinic (patient).
- Information contained in this questionnaire is confidential and will be used to draw a family tree that will be reviewed prior to the genetics appointment. The information provided will form part of the patient's health record.
- If you do not know an answer, please write "don't know" or "DK" in the space provided. If needed, please add a page with additional information.
- Please do not include information on adopted family members.
- Please make a copy for yourself.
- **Please contact our office at (519) 252-7281 ext. 350 if you are having difficulty completing this form or have questions about the information being gathered.**

## FAMILY HISTORY QUESTIONNAIRE

Full name of person referred to the genetic clinic (patient):_____
(first name) (last name)

Date of birth: _____ / _____ / _____
Day Month Year

Why has the patient been referred to the Genetics Clinic? _____

_____

Does anyone else in the family have similar problems/concerns? ☐ No ☐ Yes

If *"yes"* please list their name(s): _____

Has this patient or any family members been seen in this or another genetics clinic? ☐ No ☐ Yes

If "*yes*" please indicate who and where: _____

What are some of the concerns/questions you would like to talk about at your visit to the genetics clinic:

## Family History of Patient

**Brothers and sisters of the patient:**

| **Please list the names of the patient's brothers and sisters** (include stillbirths, miscarriages and deceased individuals) | **Sex M/F** | **Date of Birth (D/M/Y)** | **Please list any health problems, birth defects or medical diagnoses. If deceased, include cause of death and age** | **Please list the number of sons and daughters, if applicable** |
|---|---|---|---|---|
| Example: John Doe (brother to patient) | M | 03/Nov/80 | Spina bifida<br>Died heart attack Age 30 | 1 son<br>2 daughters |
| Example: miscarriage | F | 1982 | Cause unknown | |
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Do all the individuals listed above share the same two parents? ☐ No ☐ Yes

If "*No"*, please list the names of those with a different mother/father and indicate which parent they have in common with the patient (for example John Doe, same mom)

**Parents of the patient:**

| | Name | Date of Birth | Please list any significant health problems, birth defects or medical diagnoses | If deceased, please list cause of death and age |
|---|---|---|---|---|
| **Mother** | | | | |
| **Father** | | | | |

Are the parents of the patient related by blood? (for example – cousins) ☐ No ☐ Yes

If "*yes*", please explain how they are related: _____

**Children of the patient – if the patient has children, please identify this information below:**

| Please list the names of the patient's children (include stillbirths, miscarriages and deceased individuals) | Sex M/F | Date of Birth (D/M/Y) | Please list any health problems, birth defects or medical diagnoses. If deceased, include cause of death and age | Please list the number of sons and daughters, if applicable |
|---|---|---|---|---|
| Example: John Doe (son of patient) | M | 5/Nov/85 | Developmental delay | |
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## Family History of Patient's Mother

### Brothers and sisters of patient's mother (maternal aunts/uncles of patient):

| **Please list the names of the patient's maternal aunts/uncles** (include stillbirths, miscarriages and deceased individuals) | **Sex M/F** | **Date of Birth (D/M/Y)** | **Please list any health problems, birth defects or medical diagnoses. If deceased, include cause of death and age** | **Please list the number of sons and daughters, if applicable** |
|---|---|---|---|---|
| Example: Jack Jones | M | DK | Cystic fibrosis | 1 son<br>4 daughters |
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### Patient's mother's parents (maternal grandparents of patient):

| | **Name** | **Please list any significant health problems, birth defects or medical diagnoses** | **If deceased, please list cause of death and age** |
|---|---|---|---|
| **Mother** | | | |
| **Father** | | | |

What is the race/ethnic origin of the Patient's Grandmother (Mother's Mother)? _____

What is the race/ethnic origin of the Patient's Grandfather (Mother's Father)? _____

## Family History of Patient's Father

### Brothers and sisters of patient's father (paternal aunts/uncles of patient):

| **Please list the names of the patient's paternal aunts/uncles** (include stillbirths, miscarriages and deceased individuals) | **Sex M/F** | **Date of Birth (D/M/Y)** | **Please list any health problems, birth defects or medical diagnoses. If deceased, include cause of death and age** | **Please list the number of sons and daughters, if applicable** |
|---|---|---|---|---|
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### Patient's father's parents (paternal grandparents of patient):

| | **Name** | **Please list any significant health problems, birth defects or medical diagnoses** | **If deceased, please list cause of death and age** |
|---|---|---|---|
| **Mother** | | | |
| **Father** | | | |

What is the race/ethnic origin of the Patient's Grandmother (Father's Mother)? _____

What is the race/ethnic origin of the Patient's Grandfather (Father's Father)? _____

## General Family Health Information

Please complete the following for information not already mentioned in the questionnaire. Please select the appropriate box and provide the necessary details.

| Yes | No | Unsure | Condition | Name of family member(s) (please also indicate how they are related the patient) |
|---|---|---|---|---|
| | | | Birth defects (please specify) | |
| | | | Mental handicap, learning disability or slow learner | |
| | | | Three or more miscarriages | |
| | | | One or more stillbirth | |
| | | | Medical problems similar to person referred | |
| | | | Physical features similar to person referred | |
| | | | Multiple cases of cancer in your immediate family | |
| | | | Cardiac death of family member under the age of 50 | |
| | | | Anyone with muscle weakness or loose joints (double jointed) | |
| | | | Deafness or blindness from birth or as infant | |
| | | | Any health conditions that you think may be passed down in your family | |
| | | | Family members married to a blood relative (example: cousins) | |

Please use the space below to provide information on any other health concerns or other relevant family information, which has not already been provided.

Please feel free to attach additional pages if we have not provided you with enough space.