The Children's Hospital of San Antonio™
CHRISTUS Health

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Baylor College of Medicine

Genetics Clinic Family History Questionnaire

Thank you very much for taking the time to provide this information for the genetics evaluation of this patient. Since a family health history is important for each person's general medical care, we suggest that you keep a copy for your records.

PATIENT'S BIOLOGICAL PARENTS

	Name	Date of Birth	Age	Living		Health/Developmental Problems or Cause of Death	Educational Level
				Yes	No		
Mother				☐	☐		
Father				☐	☐		

Are the patient's parents currently: ☐ together ☐ married ☐ divorced ☐ separated

Are the patient's parents related by blood, for example, first cousins or second cousins? ☐ No ☐ Yes

Are the either of the biological parents thinking of having more children? ☐ No ☐ Yes

PATIENT'S SIBLINGS

Name	Sex (M/F)		Age	Living		Same mother and father (B) Same mother and different father (M) Same father and different mother (F)	Health/Developmental Problems or Cause of Death
	M	F		Yes	No		
	☐	☐		☐	☐	☐B ☐M ☐F	
	☐	☐		☐	☐	☐B ☐M ☐F	
	☐	☐		☐	☐	☐B ☐M ☐F	
	☐	☐		☐	☐	☐B ☐M ☐F	
	☐	☐		☐	☐	☐B ☐M ☐F	
	☐	☐		☐	☐	☐B ☐M ☐F	
	☐	☐		☐	☐	☐B ☐M ☐F	
	☐	☐		☐	☐	☐B ☐M ☐F	
	☐	☐		☐	☐	☐B ☐M ☐F	

PATIENT'S CHILDREN (IF APPLICABLE)

Name	Sex (M/F)		Age	Living		Health/Developmental Problems or Cause of Death
	M	F		Yes	No	
	☐	☐		☐	☐	
	☐	☐		☐	☐	
	☐	☐		☐	☐	
	☐	☐		☐	☐	
	☐	☐		☐	☐	
	☐	☐		☐	☐	

PATIENT'S MOTHER'S SIDE OF THE FAMILY

PATIENT'S MOTHER'S SIBLINGS (i.e. the maternal aunts and uncles of the patient)

Name	Sex (M/F)		Age	Living		Same mother and father (B) Same mother and different father (M) Same father and different mother (F)	Health/ Developmental Problems or Cause of Death	How many children does this person have? (number of boys/girls)
	M	F		Yes	No			
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		

PATIENT'S MOTHER'S PARENTS (i.e. maternal grandparents of the patient)

	Name	Age	Living		Health/Developmental Problems or Cause of Death
			Yes	No	
Grandmother			☐	☐	
Grandfather			☐	☐	

PATIENT'S FATHER'S SIDE OF THE FAMILY

PATIENT'S FATHER'S SIBLINGS (i.e. the paternal aunts and uncles of the patient)

Name	Sex (M/F)		Age	Living		Same mother and father (B) Same mother and different father (M) Same father and different mother (F)	Health/ Developmental Problems or Cause of Death	How many children does this person have? (number of boys/girls)
	M	F		Yes	No			
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		
	☐	☐		☐	☐	☐B ☐M ☐F		

PATIENT'S FATHER'S PARENTS (i.e. paternal grandparents of the patient)

	Name	Age	Living		Health/Developmental Problems or Cause of Death
			Yes	No	
Grandmother			☐	☐	
Grandfather			☐	☐	

OTHER RELATIVES (with medical, developmental, genetic problems, etc.)

Name	Relationship to the Patient	Sex (M/F)		Age	Living		Health/Developmental Problems or Cause of Death
		M	F		Yes	No	
		☐	☐		☐	☐	
		☐	☐		☐	☐	
		☐	☐		☐	☐	
		☐	☐		☐	☐	
		☐	☐		☐	☐	
		☐	☐		☐	☐	

	Please check any of the following that might be in your family:	Who? (Relatives relationship to the patient- ex: patient's cousin)	Comments
☐	Three or more miscarriages, infertility issues		
☐	Stillbirths		
☐	Birth defects requiring surgery (ex: cleft lip/palate, heart defects, spina bifida, limb defects)		
☐	Epilepsy or seizures		
☐	Learning or developmental problems		
☐	Hearing loss or vision loss in childhood		
☐	Metabolic problems or disorder		
☐	Down syndrome or other chromosome problems		
☐	Autism or other autism spectrum disorders		
☐	Significant kidney/bladder/genital problems		
☐	Significant heart problems (strokes, sudden death)		
☐	Significant skin problems (ex: unusual number or coloring of marks, etc.)		
☐	Significant blood problems (hemophilia, sickle cell disease)		
☐	Skeletal problems (easily broken bones, curvature of the spine, short stature < 5 ft. tall, tall stature > 6 ft. 1 in. tall)		
☐	Significant psychological problems (ex: schizophrenia, bipolar, depression)		
☐	Cancer (please specify type and age of diagnosis)		
☐	Other known genetic conditions (cystic fibrosis, muscular dystrophy)		
☐	Other health concerns (please specify)		