Family Health History Questionnaire

Instructions for using the family health history questionnaire:

1) Photocopy the questionnaire on the opposite side of this sheet for you and your family members.

2) Fill out one copy for yourself.

3) Send out the other copies to family members along with a letter explaining why you sent it. Be sure to send out extra copies for any additional people in the same household.

4) Tell your family members that they can photocopy blank questionnaires and send them to other family members.

5) Try to get all the forms back. Keep in mind that not everyone will fill out all the questions because of the sensitive nature of health information.

6) Write each individual's relationship to you at the bottom of the questionnaire after it is returned.

7) As time goes on, remember to add any new information that you might learn about your family members to their questionnaire.

Another option: You can email the questionnaire to family members. Download it here: www.geneticalliance.org/fhh

Optional Family Health History Questionnaire

Instructions: Fill out one of these questionnaires for yourself and make copies for others to fill out. You can also fill out a questionnaire for people who are deceased or cannot do it themselves. *Not all health conditions are listed.* Many other conditions, including many mental health conditions and single gene disorders also run in families.

Name: _____ Today's Date: _____

Place of Birth: _____ Date of Birth: _____

If Deceased
Cause of Death: _____ Date of Death: _____

Ethnicity: _____

Health history	**Yes**	**No**	**Not sure**	**Age of onset**
High blood pressure	☐	☐	☐	_____
High cholesterol	☐	☐	☐	_____
Heart disease or heart attack	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
Diabetes/sugar disease	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Types:_____				
Asthma	☐	☐	☐	_____
Alzheimer's disease	☐	☐	☐	_____
Birth defects	☐	☐	☐	_____
Types:_____				
Vision loss/hearing loss	☐	☐	☐	_____
Miscarriage/Stillbirth	☐	☐	☐	_____
How many? _____				

Check one:

_____Smoker _____ Ex-Smoker _____Non-Smoker _____Not Sure

Other Health Concerns:

_____
_____
_____
_____
_____