

# Family Health History Form



Fill out all pages of this form about you, your partner and your families.  
Read the directions for each section — they contain important information.

Date \_\_\_\_\_

This form does not replace the health history form that you fill out at your health care provider’s office. But you can use it to get started on your family health history. Share the form with your provider — it gives helpful information about health conditions that run in your family. It’s OK if you can’t answer all the questions on the form. Do the best you can.

## About you and your partner

	You	Your partner
Name		
Date of birth		
Job		
Marital status (single, married, divorced, widowed)		
Last grade of school completed		
Adopted	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Ethnic background:** Put a ✓ in the box or boxes if you or your partner has ancestors from these ethnic backgrounds. This information is important because some diseases, like sickle cell and Tay-Sachs, run in people from certain backgrounds or parts of the world. It’s OK to check more than one box.

	You	Your partner
African or African-American	<input type="checkbox"/>	<input type="checkbox"/>
Ashkenazi Jewish	<input type="checkbox"/>	<input type="checkbox"/>
Asian/Pacific Islander	<input type="checkbox"/>	<input type="checkbox"/>
Cajun or French Canadian	<input type="checkbox"/>	<input type="checkbox"/>
European Caucasian (from England, Germany, Ireland, Switzerland, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Hispanic (from Central or South America, Mexico, Puerto Rico, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Indian (from India)	<input type="checkbox"/>	<input type="checkbox"/>
Mediterranean (from Greece, Italy, Turkey, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Middle Eastern (from Egypt, Iran, Iraq, Lebanon, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Native American	<input type="checkbox"/>	<input type="checkbox"/>
Southeast Asian (from China, Laos, Vietnam, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Other. Please write it here:	<input type="checkbox"/>	<input type="checkbox"/>
I don’t know.	<input type="checkbox"/>	<input type="checkbox"/>

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**Medicines and supplements:** List all for you and your partner. Write the name of the medicine or supplement and how often and how much you take. If there are none, write “none.” If you don’t know, write “don’t know.”

		What? How often? How much? If there are none, write “none.” If you don’t know, write “don’t know.”
Prescription medicine	You	
	Your partner	
Over-the-counter medicine	You	
	Your partner	
Multivitamin, prenatal vitamin or other supplement	You	
	Your partner	

**Harmful substances:** List all for you and your partner. Write the name of the substance, and how often and how much you use or are exposed to it. If there are none, write “none.” If you don’t know, write “don’t know.”

		What? How often? How much? If there are none, write “none.” If you don’t know, write “don’t know.”
Smoking	You	
	Your partner	
Alcohol (beer, wine, liquor)	You	
	Your partner	
Street drugs (marijuana, cocaine, heroin, ecstasy, etc.)	You	
	Your partner	
Chemicals you use (weed killer, paint, paint thinner, turpentine, etc.)	You	
	Your partner	

**Health conditions:** Put a ✓ in the “yes,” “no” or “don’t know” box for any health conditions you, your partner or your family members have now or have had in the past. In the last column, write the family member who has the condition and which side of the family the person is from. Family members are anyone related to you by blood. Do not include family members who are adopted or part of your step-family.

	Yes	No	Don’t know	Tell us as much as you know about the person, such as the relationship to you and the person’s age when the condition started.
<i>Example: High blood pressure</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<i>My dad’s sister, 45 years old</i>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Birth defects, including heart defects or spina bifida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blindness from birth or before age 40	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	Yes	No	Don't know	Tell us as much as you know about the person, such as the relationship to you and the person's age when the condition started.
Blood clots or deep vein thrombosis (DVT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer, such as breast, ovarian or colon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cystic fibrosis (CF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Deafness from birth or before age 40	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Early menopause (before age 40)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease, including heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Intellectual disabilities, including Fragile X syndrome or learning disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mental illness, such as depression or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary embolism (PE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Repeat pregnancy losses (miscarriage, stillbirth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spinal muscular atrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sudden, unexpected death as an adult or child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tay-Sachs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thalassemia, a type of anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
von Willebrand disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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If you, your partner or someone in your families has a medical condition that is not listed above, please write about it here:

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Have you or anyone in your family had a premature baby (born before 37 completed weeks of pregnancy)?

Yes  No  Don't know

Have you, your partner or anyone in your families had genetic testing?  Yes  No  Don't know

If yes, please explain:

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Are you and your partner first cousins or in any other way blood relatives?  Yes  No

If yes, please explain how you are related:

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For more information on family health history, check out these resources:

### Does It Run in the Family?

Genetic Alliance

[www.familyhealthhistory.org](http://www.familyhealthhistory.org) or 1-202-966-5557

This online tool helps you create personalized booklets to start conversations about health in your family and community.

### Know Your Family Health History

American Society of Human Genetics and Genetic Alliance

[www.talkhealthhistory.org](http://www.talkhealthhistory.org) or 1-866-HUM-GENE (486-4363)

This site has tools and tips to help you talk to your family and your provider about health history.

### My Family Health Portrait Tool

U.S. Surgeon General's Office

<https://familyhistory.hhs.gov/fhh-web/home.action> or 1-888-478-4423

This online tool lets you take your family health history and save it on your own computer. You can update it over time.

### Your Family Health History

March of Dimes

[marchofdimes.com/familyhealthhistory](http://marchofdimes.com/familyhealthhistory)

This site includes videos about family health history and the people who are Hispanic, Chinese and African-American.

## About the March of Dimes

The March of Dimes helps moms have full-term pregnancies and healthy babies. Support research and programs that help babies at: [marchofdimes.com/howtohelp](http://marchofdimes.com/howtohelp)