# Children's National Medical Center

## Family History Genetics Questionnaire

Your answers to this Family History Questionnaire will help your care providers at Children's National to know if your family has a risk of a certain illness. Your confidential answers will give your care providers important information that may help decide future treatment. Your answers may result in a referral to a geneticist/ a genetic counselor who is very good at answering questions about family health.

### Child's Maternal Family History

*Please check (√) below each item that you/your child or any of your (or your child's) close relatives (on the mother's side (maternal) have had.. For each item you check, please tell us WHO has had this problem (ex: grandmother, aunt, cousin, father, etc.). You can write in more details on the lines below if you like.*

____Multiple miscarriages (3 or more), stillbirths or babies that died in infancy
____Birth defects (ex: cleft lip/palate, heart defects) ____ Learning problems or intellectual disability
____Hearing or vision loss in childhood ____Muscle disorder (ex: muscular dystrophy)
____Down syndrome or other genetic conditions ____ Autism or autism spectrum disorders
____Bleeding disorders ____ Multiple fractures with minimal trauma
____Skin problems (ex: unusual birthmarks, etc) ____Cancer prior to 50 years old
____Sudden unexplained death ____Other health concerns
____Special dietary needs or limitations (ex: no protein, biotin supplements)

_____
_____

### Child's Paternal Family History

*Please check (√) below each item that you/your child or any of your (or your child's) close relatives (on the father's side (paternal)) have had. For each item you check, please tell us WHO has had this problem (ex: grandmother, aunt, cousin, father, etc.). You can write in more details on the lines below if you like.*

____Multiple miscarriages (3 or more), stillbirths or babies that died in infancy
____Birth defects (ex: cleft lip/palate, heart defects) ____ Learning problems or intellectual disability
____Hearing or vision loss in childhood ____Muscle disorder (ex: muscular dystrophy)
____Down syndrome or other genetic conditions ____ Autism or autism spectrum disorders
____Bleeding disorders ____ Multiple fractures with minimal trauma
____Skin problems (ex: unusual birthmarks, etc) ____Cancer prior to 50 years old
____Sudden unexplained death ____Other health concerns
____Special dietary needs or limitations (ex: no protein, biotin supplements)

_____
_____

Are you considering having children or having more children? Yes_____ No_____
If you would like to meet with a genetic counselor to discuss reproductive risks check here ____
I would like a geneticist to evaluate me/my child Yes____ No____

**Child's School/development history**

Do you or does anyone else have any concerns about your child's development? Yes No
If **yes**, please explain:_____
Does your child have special learning needs? Yes No
If **yes**, please explain. _____
Does your child receive any therapies (e.g., physical, occupational, speech, other)? Yes No
If **yes**, please explain._____

### Child's Past Medical History

*Please list any specialty doctors you/ your child see aside from a primary care doctor or dentist*

| Name of doctor | Specialty | Reason | How often? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Pregnancy History of Patient's Mother**

| | Yes | No | Detail |
|---|---|---|---|
| Any complications during the pregnancy? | | | |
| Is mom pregnant now? | | | Due date: |

Mother's age now: _____years Father's age now: _____years

Nursing notes (additional observations)
:_____
_____
_____
_____
_____
_