

Family Medical History Questionnaire



Public reporting burden for this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-xxxx*). Do not return the completed form to this address.

Instructions

Please complete the Family Medical History questionnaire as best as you can. If you don't know the answer to one or more questions or have the information you need to complete the questionnaire, please don't guess. Instead, please contact your biological mother, father, or full brothers and sisters and ask them to help you complete the questionnaire. If you need help or have questions while completing this questionnaire, please call XXX-XXX-XXXX.

The following questions are about your parents and siblings, not your children.

1. Were you raised by your biological parent or parents, adoptive parents, foster parents, or other relatives? (MARK ALL THAT APPLY.)

- Biological parent(s) → Q3
- Adoptive parent(s)
- Foster parent(s)
- Other relatives, specify: _____
- Don't know

2. Do you know **anything** about the health conditions of your biological relatives?

- Yes
- No → END
- Don't know

3. How many full siblings do you have? By full sibling, we mean brothers or sisters you have with the same biological mother and father.

NUMBER OF FULL SIBLINGS

- No siblings
- Don't know

4. Is your biological mother still living?

- Yes → Q7
- No
- Don't know → Q7

5. What was the cause of her death?

MOTHER'S CAUSE OF DEATH

- Don't know

6. How old was she when she died? If you aren't sure how old she was when she died, please guess as closely as you can.

AGE

- Don't know

7. Is your biological father still living?

- Yes → Q10
- No
- Don't know → Q10

8. What was the cause of his death?

FATHER'S CAUSE OF DEATH

- Don't know

9. How old was he when he died? If you aren't sure how old he was when he died, please guess as closely as you can.

AGE

- Don't know

Please answer the following questions about your biological mother and father, as well as any full brothers and/or sisters you have.

	Mother	Father	Full Brother/Sister # 1
Heart attack?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">↓</div> Did she have a heart attack before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">↓</div> Did he have a heart attack before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">↓</div> Did s/he have a heart attack before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Angioplasty or coronary bypass surgery?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">↓</div> Did she have angioplasty or coronary bypass surgery before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">↓</div> Did he have angioplasty or coronary bypass surgery before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">↓</div> Did s/he have angioplasty or coronary bypass surgery before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Asthma?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Eczema or atopic dermatitis?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Allergies?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
High blood pressure?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know




	Full Brother/Sister # 2	Full Brother/Sister # 3	Full Brother/Sister # 4
Heart attack?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Did s/he have a heart attack before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Did s/he have a heart attack before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Did s/he have a heart attack before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Angioplasty or coronary bypass surgery?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Did s/he have angioplasty or coronary bypass surgery before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Did s/he have angioplasty or coronary bypass surgery before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Did s/he have angioplasty or coronary bypass surgery before age 55? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Asthma?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Eczema or atopic dermatitis?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Allergies?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
High blood pressure?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know




	Mother	Father	Full Brother/Sister # 1
Diabetes?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Was she diagnosed with diabetes as a child or teenager? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Has she ever used insulin shots or an insulin pump to treat diabetes? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Was he diagnosed with diabetes as a child or teenager? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Has he ever used insulin shots or an insulin pump to treat diabetes? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Was s/he diagnosed with diabetes as a child or teenager? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Has s/he ever used insulin shots or an insulin pump to treat diabetes? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
High cholesterol?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Any type of cancer?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know What type of cancer was she diagnosed with: _____ _____	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know What type of cancer was he diagnosed with: _____ _____	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know What type of cancer was s/he diagnosed with: _____ _____

	Full Brother/Sister # 2	Full Brother/Sister # 3	Full Brother/Sister # 4
Diabetes?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Was s/he diagnosed with diabetes as a child or teenager? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Has she ever used insulin shots or an insulin pump to treat diabetes? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Was s/he diagnosed with diabetes as a child or teenager? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Has s/he ever used insulin shots or an insulin pump to treat diabetes? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Was s/he diagnosed with diabetes as a child or teenager? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know Has s/he ever used insulin shots or an insulin pump to treat diabetes? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
High cholesterol?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Any type of cancer?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know What type of cancer was s/he diagnosed with: _____ _____	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know What type of cancer was s/he diagnosed with: _____ _____	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know What type of cancer was s/he diagnosed with: _____ _____

	Mother	Father	Full Brother/Sister # 1
Thyroid disease?	<p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with an underactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with an overactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with some other thyroid disease? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> If Yes, specify thyroid disease: _____ </p>	<p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was he diagnosed with an underactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was he diagnosed with an overactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was he diagnosed with some other thyroid disease? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> If Yes, specify thyroid disease: _____ </p>	<p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with an underactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with an overactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with some other thyroid disease? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> If Yes, specify thyroid disease: _____ </p>

	Full Brother/Sister # 2	Full Brother/Sister # 3	Full Brother/Sister # 4
Thyroid disease?	<p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with an underactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with an overactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with some other thyroid disease? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> If Yes, specify thyroid disease: _____ </p>	<p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with an underactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with an overactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with some other thyroid disease? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> If Yes, specify thyroid disease: _____ </p>	<p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with an underactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with an overactive thyroid? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> Was s/he diagnosed with some other thyroid disease? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know </p> <p> If Yes, specify thyroid disease: _____ </p>

	Mother	Father	Full Brother/Sister # 1
Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Autism, Asperger syndrome or other autism spectrum disorder?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
An eating disorder such as anorexia or bulimia?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Alcoholism?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Bipolar disorder?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Depression other than bipolar disorder?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Schizophrenia?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Anxiety disorder such as generalized anxiety disorder (GAD) or obsessive compulsive disorder (OCD)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">  <p>What type of anxiety disorder was she diagnosed with:</p> <p>_____</p> </div>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">  <p>What type of anxiety disorder was he diagnosed with:</p> <p>_____</p> </div>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">  <p>What type of anxiety disorder was s/he diagnosed with:</p> <p>_____</p> </div>
Mental retardation?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know

	Full Brother/Sister # 2	Full Brother/Sister # 3	Full Brother/Sister # 4
Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Autism, Asperger syndrome or other autism spectrum disorder?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
An eating disorder such as anorexia or bulimia?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Alcoholism?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Bipolar disorder?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Depression other than bipolar disorder?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Schizophrenia?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Anxiety disorder such as generalized anxiety disorder (GAD) or obsessive compulsive disorder (OCD)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">  <p>What type of anxiety disorder was s/he diagnosed with:</p> <p>_____</p> </div>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">  <p>What type of anxiety disorder was s/he diagnosed with:</p> <p>_____</p> </div>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know <div style="text-align: center;">  <p>What type of anxiety disorder was s/he diagnosed with:</p> <p>_____</p> </div>
Mental retardation?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know