

SELF-ADMINISTERED FAMILY HISTORY – Long form
 Neuro Genetics & Neuro Oncology Genetics Clinic
 Molecular and Medical Genetics
 Oregon Health & Sciences University (OHSU)

Attach patient label here

This form will help us understand your family history and prepare for your Genetics visit. We appreciate your time!

Check if any family members have the following:

___ the same condition as the patient we are seeing ___ other conditions that appear to run in the family
If so, please tell us more about those family members as they appear in the form or on the last page.

Children of patient (skip if the patient does not have any children)

First Name	Sex M/F	Age	Living Y/N	Medical Problems	Mother's First Name	Father's First Name

Brothers and sisters of patient

First Name	Sex M/F	Age	Living Y/N	# Children		Medical Problems	Mother's First Name	Father's First Name
				Male	Female			

If there are any health problems with the brothers' and sisters' children (patient's nieces and nephews), please note.

Mother's Family History

Mother's First Name	Age	Living Y/N	Age of Death	# Children		Medical Problems
				Male	Female	

Mother's brothers and sisters (uncles and aunts of the patient)

First Name	Sex M/F	Age	Living Y/N	# Children		Medical Problems	Mother's First Name	Father's First Name
				Male	Female			

If there are any health problems with the brothers' and sisters' children (patient's cousins), please note.

Mother's parents (maternal grandparents of the patient)

First Name	Age	Living Y/N	Age of Death	# Children		Medical Problems
				Male	Female	

Father's Family History

Father's First Name	Age	Living Y/N	Age of Death	# Children		Medical Problems
				Male	Female	

Father's brothers and sisters (uncles and aunts of the patient)

First Name	Sex M/F	Age	Living Y/N	# Children		Medical Problems	Mother's First Name	Father's First Name
				Male	Female			

If there are any health problems with the brothers' and sisters' children (patient's cousins), please note.

Father's parents (paternal grandparents of the patient)

First Name	Age	Living Y/N	Age of Death	# Children		Medical Problems
				Male	Female	

Extra Sheet

Please feel free to include information on any other family members that you didn't have room for or any individuals with birth defects, genetic conditions, or other things that you are worried about.

First Name	Relationship to Patient	Sex M/F	Age	Living Y/N	Medical Problems	Mother's First Name	Father's First Name