

WILLIS KNIGHTON PEDIATRICS GENETICS PROGRAM
 2032 Elizabeth Ave, Shreveport, LA, 71104 • Pediatric Clinic: 318-698-0035
 Genetics Office: 318-212-6259 • Genetics FAX: 318-212-6249

PERSONAL AND FAMILY HISTORY QUESTIONNAIRE

INSTRUCTIONS: Please complete this form to the best of your ability **PRIOR** to your appointment. Please remember to list **ALL** relatives, living and deceased, regardless of if they have the health concern in question. If you are unsure about a family member's health history, please try to discuss this with a relative **PRIOR** to the appointment. Bring any **COPIES** of genetic testing results to the appointment if testing completed for family members in the past.

DEMOGRAPHIC INFORMATION:

Child's Name:	Date:
Date of Birth:	Parent's Email for Testing Results:
Mother's name:	Father's name:
Mother's phone number:	Father's phone number:
Referring Provider:	Contact's Phone:
Primary Care Provider (if different from above):	Other Care Providers (if different from above):

Mother's family ancestry (countries of origin outside the USA): _____

Father's family ancestry (countries of origin outside the USA): _____

**ON THE FOLLOWING PAGES, PLEASE LIST ALL FAMILY MEMBERS ALIVE OR DECEASED.
 (even those without a history of the current health concern, cancer, or pertinent disorder)**

Add any additional family members on a separate piece of paper if needed. Please include a copy of genetic testing results if possible. If you have any pathology reports on family members with cancer or pre-cancer, please bring that with you to the visit also.

PLEASE BRING THIS COMPLETED PACKET TO YOUR APPOINTMENT:

DATE: _____ **TIME:** _____ **OFFICE:** _____



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FAMILY HEALTH HISTORY continued

YOUR CHILD'S BROTHERS AND SISTERS: (please list all, even those without health concerns)

Name:	If Sibling is half Sibling, what side?	Sex:	Current Age:	Age at Death:	Health Concerns:	Age at Diagnosis:
	<input type="checkbox"/> Full <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F				
	<input type="checkbox"/> Full <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F				
	<input type="checkbox"/> Full <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F				
	<input type="checkbox"/> Full <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F				
	<input type="checkbox"/> Full <input type="checkbox"/> Same Mother <input type="checkbox"/> Same Father	M / F				

YOUR CHILD'S BROTHERS AND SISTERS: (please list all, even those without health concerns)

Name:	Parent Name:	Sex:	Current Age:	Age at Death:	Health Concerns:	Age at Diagnosis:
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				



**WILLIS KNIGHTON PEDIATRICS GENETICS PROGRAM
FAMILY HEALTH HISTORY continued**

YOUR CHILD'S FATHER AND GRANDPARENTS: (please list all, even any without health concerns)

Relative:	Name:	Current Age:	Age at Death:	Health Concerns:	Age at Diagnosis:
Father					
Paternal Grandfather					
Paternal Grandmother					

YOUR CHILD'S AUNTS AND UNCLES ON DAD'S SIDE: (please list all, even any without health concerns)

Name:	Sex:	Current Age:	Age at Death:	Health Concerns:	Age at Diagnosis:
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				

YOUR CHILD'S 1st COUSINS ON DAD'S SIDE (please list all, even those without health concerns)

Name:	Parent Name:	Sex:	Current Age:	Age at Death:	Health Concerns:	Age at Diagnosis:
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				
		M / F				



**WILLIS KNIGHTON PEDIATRICS GENETICS PROGRAM
FAMILY HEALTH HISTORY continued**

YOUR CHILD'S MOTHER AND GRANDPARENTS: (please list all, even those without health concerns)					
Relative:	Name:	Current Age:	Age at Death:	Health Concerns:	Age at Diagnosis:
Mother					
Grandfather					
Grandmother					

YOUR CHILD'S AUNTS AND UNCLAS ON MOM'S SIDE: (please list all, even any without health concerns)					
Name:	Sex:	Current Age:	Age at Death:	Health Concerns:	Age at Diagnosis:
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				

YOUR CHILD'S 1st COUSINS ON MOM'S SIDE (please list all, even those without health concerns)					
Name:	Parent Name:	Sex:	Current Age:	Age at Death:	Cancer Type or Pertinent Disorder of Concern:
		M / F			
		M / F			
		M / F			
		M / F			
		M / F			
		M / F			
		M / F			

