

Family History Checklist

Have you, your partner, or anyone in your family or your partner's family had:

You or Your Family

Your Partner or His Family

Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disorders (rheumatoid arthritis, lupus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric disorders	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>
Preeclampsia	<input type="checkbox"/>	<input type="checkbox"/>
Difficult labor	<input type="checkbox"/>	<input type="checkbox"/>

Are there any genetic conditions in your family or your partner's, such as:

Down syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Any chromosomal abnormality	<input type="checkbox"/>	<input type="checkbox"/>
Neural tube defects, including spina bifida, meningocele, and anencephaly	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Connective tissue disease	<input type="checkbox"/>	<input type="checkbox"/>
Neurological disorders	<input type="checkbox"/>	<input type="checkbox"/>
Mental retardation/autism	<input type="checkbox"/>	<input type="checkbox"/>
If yes, was person tested for fragile X?	<input type="checkbox"/>	<input type="checkbox"/>
Tay-Sachs disease	<input type="checkbox"/>	<input type="checkbox"/>
Thalassemia	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>
Cystic fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
Phenylketonuria (PKU)	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Canavan disease	<input type="checkbox"/>	<input type="checkbox"/>
Huntington's chorea	<input type="checkbox"/>	<input type="checkbox"/>
Other genetic disorders	<input type="checkbox"/>	<input type="checkbox"/>

Are there any sets of fraternal twins or other multiples in your family?

Are there any allergies in your family, including food allergies?

Has anyone in your family had recurrent miscarriages or stillbirths?

Has there been a history of violence, trauma, or physical, sexual, or emotional abuse in your family, or in your relationship?

Was your mother given diethylstilbestrol (DES) when she was pregnant with you?