

PSYCHIATRIC FAMILY GENETIC HISTORY QUESTIONNAIRE

BACKGROUND: As a group, psychiatric disorders have a relatively high heritability. This means that genetics is a major factor in the development of these problems and illnesses. A careful assessment of the family history of these problems is quite helpful in diagnosis and treatment planning. With the human genome project now completed and ever more information available about genetics, this family history information is becoming increasingly important. A family history of problems suggests the presence of genetic risk. Remember, genetic risk increases the probability of developing a similar or related problem, but genes are not destiny. Many other factors (including we hope, early recognition and treatment) play an important role in whether a problem will develop and at what level of severity.

GENERAL DIRECTIONS: This is a lengthy and somewhat complicated questionnaire, but please hang in there and take it step by step since it is quite important. For a genetic history we are considering your “blood relatives.” You can greatly increase how accurate and complete this information is by making sure to follow these proven principles:

- a) get information from more than one family member on your mother’s and father’s sides
- b) first identify all close relatives by name and age
- c) take time to carefully consider each and every close relative for each kind of problem, and
- d) include whatever information you have

An adult patient will typically complete this history themselves, consulting members from both sides of their family. Read all the directions for Step A, and then complete it. Next, read all the items for Step B and complete it. Take a quick look now at the accompanying “Recording Form” you will use to record the information.

STEP A: Listing ALL the close relatives (simpler than it looks).

1. Write in who completed the **mother’s side** history (e.g., Mom-Julie), and circle yes or no regarding whether other family members were consulted (hopefully yes!).
2. Write your mother’s first name and age. For age, if the person is 20 or older, simply write the decade of life (e.g., 40s), if younger than 20, then write your best estimate of the age.
3. Then write the first names of your grandmother and grandfather and their ages.
4. If someone is deceased, write the age at which they had died (e.g., 50s), and draw a light diagonal line through the age.
5. Next write down **all** maternal (mother’s blood relatives) aunts and uncles first names (do not include half aunts/uncles).
6. Write down **all** brothers and sisters (listed as “siblings”). Include half-siblings, and put ½ after the word “sibling”. For siblings, indicate if they are male (m) or female (f) after their age (e.g., 14f). If you have children, these can be listed in the “Other” section or on the back.
7. Now repeat all the above steps for your **father’s side**.

Step B: Listing the family history.

1. Carefully read through the list of problems on the next page.
2. Have a conversation with one or two members on the mother’s side of the family to gather information.
3. Start at the top with the mother’s side (the patient’s mother) and systematically go through each person. Think about all you know about this person, and then deliberately go through each item on the problem list to consider whether each of the problems is present in that person’s history.

4. Each time the problem is present, indicate that by writing the “code” (the bold face letters) on the line following the person’s age. Write as many problems as are present (e.g., hosp. suid. diag. med. drug).
5. On the full line below the family member’s name, write additional details or information (e.g., hosp. in 20s, bipolar, suicide attempt, lithium, marijuana). Use the back of the paper to add more details if available.
6. Now repeat these steps with the father’s side.
7. Celebrate, you’ve finished! Keep a copy for yourself.

Problem List

(Please remember to consider each of these questions for each of the close relatives)

1. Has this relative ever been **hospitalized** for psychiatric or substance abuse problems?
2. Has this relative ever made **suicidal** statements or had suicidal behavior?
3. Has this relative ever had clearly bizarre/**psychotic** behavior or thinking, hallucinations, or very strange untrue beliefs (delusions)?
4. Has this relative ever been treated with **medications** for a psychiatric or emotional/behavioral problem (e.g., medicine for depression, anxiety, or hallucinations)? If known, write the name of the medicine.
5. Has this relative ever had a **diagnosis** for a psychiatric or emotional/behavioral problem? This would include problems such as depression, mania, bipolar disorder, anxiety, ADHD/hyperactivity, schizophrenia, tic disorders, panic disorder, enuresis, etc.
6. Has this relative ever had persistent moodiness or rapid emotional or mood **swings** that caused very serious problems?
7. Has this relative ever had **criminal** behavior involving the police or courts (include if this was in the juvenile justice system)?
8. Has this relative ever had an **alcohol** abuse problem?
9. Has this relative ever had a **drug** abuse problem?
10. Has this relative ever had problems with recurrent **aggression**, violence, or serious explosive anger?
11. Has this relative ever had problems with **learning** or a learning disorder (e.g., reading disorder or dyslexia)?
12. Has this relative ever had problems with a **developmental** disorder (e.g., mental retardation or autism-like problems)?
13. Has this relative ever had problems with a known **genetic** disorder that runs in the family?

Family Genetic History Recording Form

Patient's First and Last Name, Age, and Gender: _____

MOTHER'S Side: Completed by: _____ Consulted others: Yes or No

Relationship to Patient First Name Age History

Mother _____

Grandmother _____

Grandfather _____

Aunt/Uncle _____

Aunt/Uncle _____

Aunt/Uncle _____

Oldest Child/Sibling _____

Next Child/Sibling _____

Next Child/Sibling _____

Other: _____

FATHER'S Side: Completed by _____ Consulted Others: Yes or No

Relationship to Patient First Name Age History

Father _____

Grandmother _____

Grandfather _____

Aunt/Uncle _____

Aunt/Uncle _____

Aunt/Uncle _____

Oldest Child/Sibling _____

Next Child/Sibling _____

Next Child/Sibling _____

Other: _____

SOCIAL, PEER, AND EDUCATIONAL HISTORY

(check those which are consistent with your history)

- ___ Had difficulty with reading
- ___ Had difficulty with arithmetic
- ___ Had difficulty with spelling
- ___ Had difficulty with writing

___ Had difficulty with other subjects (please list)

___ Had an identified learning disability (if yes, please describe):

___ Was in a special education class (If yes, please describe):

___ Had difficulty socially (if yes, what grade and why):

___ Had difficulty with behavior (if yes, please describe):

___ Educational attainment:

GENERAL MEDICAL HISTORY

How is your general health currently? Excellent Good Fair Poor Explain: _____

Have there been concerns about growth or weight? No Yes Explain: _____

Any problems with vision or hearing? No Yes Explain: _____

Any serious chronic illnesses now or in the past? No Yes Explain: _____

Please list any overnight hospitalizations (with reasons and age)? _____

Any surgeries (for what and at what age); any continuing related problems? No Yes Explain: _____

Serious injuries? No Yes Explain: _____

Allergies to medicine or serious allergies? No Yes Explain: _____

When was your last complete physician examination: Month/year: _____ Were there any problems identified? No Yes Explain: _____

Any special dietary requirements? No Yes Explain: _____

Has you had any of the following (please give details):

head injuries: No Yes Explain: _____

episodes of loss of consciousness: No Yes Explain: _____

current problems with sleep: No Yes Explain: _____

seizures: No Yes Explain: _____

recurrent headaches: No Yes Explain: _____

abnormal movements, tics, or tremors: No Yes Explain: _____

change in sensation: No Yes Explain: _____

change in movement, coordination, or walking: No Yes Explain: _____

change in speech: No Yes Explain: _____

recurrent ear infections: No Yes Explain: _____

changes in weight or concern about eating problems or disorders (e.g., anorexia): No Yes Explain: _____

persistent fatigue or fevers: No Yes Explain: _____

skin changes: No Yes Explain: _____

breathing or lung problems: No Yes Explain: _____

heart or blood pressure problems: No Yes Explain: _____

fainting or irregular heart beat: No Yes Explain: _____

urination problems or wetting: No Yes Explain: _____

bowel problems or soiling: No Yes Explain: _____

liver injury, infection, or other problems: No Yes Explain: _____

recurrent nausea, vomiting, or diarrhea: No Yes Explain: _____

delays or advances in onset of puberty: No Yes Explain: _____

menstrual problems or sexually transmitted infections: No Yes Explain: _____

kidney injury, infections, or other problems: No Yes Explain: _____

problems with bones, muscles, or joints, including recurrent pain: No Yes Explain: _____

other: No Yes Explain: _____

Are you taking herbals, dietary supplements, and/or vitamins No Yes
Please list the supplements and amount taken: _____

Are you taking any regular medications (include nonprescription)? No Yes

Please list the medication and current dose: _____
