Family History Questionnaire for Inherited Cardiac Disorders

Patient Name:______________________Date of Birth:________________ Gender: M / F Ethnicity: _________________________

Phone: _____________________________ Email: _______________________________________Date Completed: __________________

Please complete this questionnaire to assist your healthcare provider in determining if your personal or family medical history suggests that you or other family members have an inherited cardiac disorder. Genetic testing may be recommended based on the reported cardiac conditions.

Tips: • Each row should be completed independently • Affected relatives on your mother's side of the family should be listed in the pink boxes and affected relatives on your father's side of the family should be listed in the blue boxes • Age at diagnosis is the age at which the cardiac disease/condition was symptomatic or clinically diagnosed by a physician.

Has genetic testing been done for you or any family member? ☐ Self ☐ Relative

Cardiac tests done to date (check all that apply): ☐ ECG (electrocardiogram) ☐ Echo (echocardiogram) ☐ Cardiac MRI ☐ Stress Test

☐ Other: ____

	You	Immediate Blood Relatives		Extended Blood Relatives (Aunts, Uncles, Grandparents, etc.)			
Disease/Condition	**Age of Diagnosis**	**Parents, Siblings or Children**	**Age of Diagnosis**	**Mother's Side**	**Age of Diagnosis**	**Father's Side**	**Age of Diagnosis**
Affected with cardiomyopathy (thickened or thinned heart muscle)							
Affected with arrhythmia (irregular heart rate)							
Affected with aortic aneurysm (thoracic, abdominal)							
Sudden unexpected death of unknown cause (ex. drowning of a good swimmer; sudden, unexplained car accident)							
Syncope/fainting during exercise							
Episodes of syncope/fainting during normal activity							
Sudden or early heart attack							
Cardiac arrest							
Heart Failure or heart transplant							
ICD/pacemaker							
Elevated or high cholesterol levels							
Atherosclerosis							
Any extracardiac features (muscle weakness, dysmorphic features, deafness)							
Any problems with exercise							
Any chronic illness (ex. Hypertension - HTN)							
Muscle disorder or muscular dystrophy							
Other diseases that are genetic or run in your family ______________________________							
Any other problems related to the heart not mentioned above ______________________________							

Patient Signature ____ Date ____________________

Patient Pedigree

Pedigree Key

	Male	Female
Unaffected		
Affected		
Carriers of a gene mutation but asymptomatic or not affected		
Person has died		

Proband (first person tested and/ or first person diagnosed in the family)

Pregnancy

No children

Miscarriage or stillbirth

Office Notes

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