FAMILY HISTORY QUESTIONNAIRE

INSTRUCTIONS/INFORMATION:

We ask that a **family member of the person** who has, or has had, a memory disorder or dementing illness, **fill out the questionnaire**. For clarity, the person with the memory disorder is designated as the "Patient"; all other persons are identified in terms of their relationship to the Patient, (i.e. the patient's children, brothers, sisters, etc.). **You are encouraged to consult with other family members about the information elicited in this questionnaire**. All Information obtained will be kept strictly confidential.

Please keep the following in mind when completing this questionnaire:

1. DO NOT USE NICKNAMES.
2. When listing the children of any individual please include any miscarriages, stillbirths, therapeutic abortions, and adoptions.
3. For twins, please indicate if they are identical or fraternal.
4. Please indicate half-brothers and half-sisters; try to provide as much information on the half-sibling's other parent as possible.
5. When listing a female, please be sure to list her maiden and married name.
6. If more space is needed to list all of the individuals, please use the blank page provided at the end of the questionnaire.
7. If you are uncertain of the date or age, please try to estimate to the nearest year.
8. Please complete as much of the form as possible.

Thank you for your assistance.

SECTION 1: GENERAL INFORMATION

The Family History of _____
(Patient's Name)

Date of Initial Contact: _____

1. Name of person completing this form: _____

Address: _____

_____

_____

Preferred Phone: _____ Email: _____

Relationship to the Patient (circle one)
(1) Spouse (4) Sister
(2) Daughter (5) Brother
(3) Son (6) Other (specify) _____

2. List names, addresses, and phone numbers of other close relatives or friends who are most informed about this person's family tree and would be willing to offer their assistance:

NAME	ADDRESS	TELEPHONE	RELATIONSHIP

SECTION 2: PATIENT

Name _____ Sex _____ Date of Birth _____
(First, Maiden, Last)

Birthplace _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

SECTION 3: SPOUSE(S) OF THE PATIENT

How many times has the patient been married? _____. If the patient has been married more than once, please fill out a section for each spouse.

SPOUSE 1:

Name _____ Sex _____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____
Cause of death: _____
Place of death (city & state): _____
If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

SPOUSE 2:

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

SECTION 4: CHILDREN OF THE PATIENT

How many children does/did the patient have? _____. If the patient has been married more than once, please indicate which spouse is the parent of each child.

CHILD 1:

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

CHILD 2:

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure		
Senility or dementia	Y	N	?	Onset age:	_____
Memory disorder	Y	N	?	Onset age:	_____
Behavior change	Y	N	?	Onset age:	_____
Parkinson's disease	Y	N	?	Onset age:	_____
Stroke	Y	N	?	Onset age:	_____
Head Injury	Y	N	?		
- Loss of consciousness	Y	N	?		
- Fracture	Y	N	?		

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

CHILD 3:

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure		
Senility or dementia	Y	N	?	Onset age:	_____
Memory disorder	Y	N	?	Onset age:	_____
Behavior change	Y	N	?	Onset age:	_____
Parkinson's disease	Y	N	?	Onset age:	_____
Stroke	Y	N	?	Onset age:	_____
Head Injury	Y	N	?		
- Loss of consciousness	Y	N	?		
- Fracture	Y	N	?		

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

CHILD 4:

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure		
Senility or dementia	Y	N	?	Onset age:	_____
Memory disorder	Y	N	?	Onset age:	_____
Behavior change	Y	N	?	Onset age:	_____
Parkinson's disease	Y	N	?	Onset age:	_____
Stroke	Y	N	?	Onset age:	_____
Head Injury	Y	N	?		
- Loss of consciousness	Y	N	?		
- Fracture	Y	N	?		

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

CHILD 5:

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure		
Senility or dementia	Y	N	?	Onset age:	_____
Memory disorder	Y	N	?	Onset age:	_____
Behavior change	Y	N	?	Onset age:	_____
Parkinson's disease	Y	N	?	Onset age:	_____
Stroke	Y	N	?	Onset age:	_____
Head Injury	Y	N	?		
- Loss of consciousness	Y	N	?		
- Fracture	Y	N	?		

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

SECTION 5: PARENTS OF THE PATIENT

MOTHER:

Name _____ Sex _____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

FATHER:

Name _____ Sex _____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

SECTION 6: HALF-BROTHERS & HALF-SISTERS OF THE PATIENT

How many half-brothers and half-sisters does the patient have? _____. Please indicate the common parent and try to provide as much information as possible on the other parent.

HALF-SIBLING 1: Same mother or father as patient: _____

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

HALF SIBLING 2: Same mother or father as patient: _____

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

SECTION 7: SIBLINGS (BROTHERS & SISTERS) OF THE PATIENT

How many brothers and sisters does the patient have? _____. Include any that died in childhood, and list in chronological order (do not list patient).

SIBLING 1:

Name _____ Sex _____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

SIBLING 2:

Name _____ Sex _____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

SIBLING 3:

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

SIBLING 4:

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

SIBLING 5:

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

SIBLING 6:

Name _____ Sex ____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

SECTION 8: OTHER AFFECTED RELATIVES

If the patient has or had any other relatives (grandparents, aunts, uncles, cousins, etc.) who have or have had memory difficulties or Alzheimer's disease that we have not asked about, please list each relative below:

RELATIVE 1:

Relationship to patient: _____ Mother or father's side: _____

Name _____ Sex _____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email:

RELATIVE 2:

Relationship to patient: _____ Mother or father's side: _____

Name _____ Sex _____ Date of Birth _____
(First, Maiden, Last)

If deceased, age at death and date/year: _____

Cause of death: _____

Place of death (city & state): _____

If autopsy, where performed: _____

Has he or she ever had any of the following illnesses:

	Yes	No	Unsure	
Senility or dementia	Y	N	?	Onset age: _____
Memory disorder	Y	N	?	Onset age: _____
Behavior change	Y	N	?	Onset age: _____
Parkinson's disease	Y	N	?	Onset age: _____
Stroke	Y	N	?	Onset age: _____
Head Injury	Y	N	?	
- Loss of consciousness	Y	N	?	
- Fracture	Y	N	?	

May we contact this relative? Yes No

If yes, please fill in the relative's address and phone number below:

Street City State Zip

Preferred Phone: Email: