

## Family History Questionnaire



Name:

Surname:

Date of birth:

Birth number /  
Personal ID:

Insurance company:

Nationality:

Address of residence:

Occupation (job classification):

Occupational health risks  
(e.g. radiation, chemicals,...):

### A. DATA ON YOUR HEALTH STATUS

Do you have any congenital anomaly or birth defect?

Yes  No

If you do, which one?

#### Past or current diseases:

Apart from common childhood illnesses, were you otherwise seriously ill?

Yes  No

If so, were/are you treated or monitored for:

hearing  
impairment

poor vision

heart disease

allergy

high blood  
pressure

migraine

epilepsy

kidney disease

thyroid disorder

intestinal  
disease

atopic eczema

asthma

stuttering

lung disease

gout

diabetes

mental illness

movement  
disorders

cancer diagnosis (state age of diagnosis and type of tumor):

I suffer from other disorders and diseases (list):

Did you have any surgeries or accidents?

Yes  No

If so, what surgeries or injuries and at what age?

Do you take any medication permanently?

Yes  No

If so, what medication?

For women - Did you have a spontaneous abortion?

Yes  No

If so, state how many times and the pregnancy week:

#### When you are treated or monitored for one of the above stated conditions:



PLEASE BRING YOUR MEDICAL REPORTS, FOR CANCER INCLUDING RESULTS  
OF TUMOR HISTOLOGY!

State the name, expertise (specialization) and address of your treating physician (specialist):

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Kostelní 292/9, 170 00 Praha 7

[info@gennet.cz](mailto:info@gennet.cz)

+420 222 313 000

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CIN: 27080234  
VATIN: CZ699004108

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Court of Prague, section C, file 94758

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# Family History Questionnaire



## B. DATA ON YOUR FAMILY

Was there a consanguineous marriage in your family?

Yes  No

If so, state which relatives:

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Were there miscarriages or stillbirths in the family?

Yes  No

If so, state which relatives:

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Were twins born in your family?

Yes  No

If so, state which relatives:

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**CHILDREN:** State the name, year of birth and health status of your children from the oldest to the youngest. If the children come from multiple marriages or relationships, state the name of the other parent.

Name and surname	Year of birth	Health status (diseases, congenital defects, type of tumor and age of diagnosis, causes and age of death)	Number of daughters	Number of sons
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----

Note: List your other possible children in the supplementary note on the last page of the form. When your children have a defect or suffer from a disease, please state whether and where they are treated or monitored in the supplementary note on the last page of the form.

**SIBLINGS:** State full name, year of birth and diseases of your siblings from the oldest to the youngest. For half siblings state whether you have mother or father in common.

Name and surname	Year of birth	Health status (diseases, congenital defects, type of tumor and age of diagnosis, causes and age of death)	Number of daughters	Number of sons
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----
-----	-----	-----	-----	-----

Note: List your other possible siblings in the supplementary note on the last page of the form.

# Family History Questionnaire



**PARENTS:** State the name, year of birth and health status of your parents.

	Name and surname (also maiden name)	Year of birth	Health status (diseases, congenital defects, type of tumor and age of diagnosis, causes and age of death)	Number of daughters	Number of sons
Mother					
Father					

**MATERNAL FAMILY:** State names and surnames of your mother's parents and siblings.

	Name and surname (also maiden name)	Year of birth	Health status (diseases, congenital defects, type of tumor and age of diagnosis, causes and age of death)	Number of daughters	Number of sons
Mother's mother					
Mother's father					
1. sibling					
2. sibling					
3. sibling					

Note: list other possible maternal siblings in the supplementary note on the last page of the form.

**PATERNAL FAMILY:** State names and surnames of your father's parents and siblings.

	Name and surname (also maiden name)	Year of birth	Health status (diseases, congenital defects, type of tumor and age of diagnosis, causes and age of death)	Number of daughters	Number of sons
Father's mother					
Father's father					
1. sibling					
2. sibling					
3. sibling					

Note: list other possible paternal siblings in the supplementary note on the last page of the form.

## Family History Questionnaire



**Are you aware of congenital disorders (CD) in your cousins and their children or in extended family?**

Yes  No

If so, state which relatives and what CD:

**Are you aware of cancer in your cousins and their children or in extended family?**

Yes  No

If so, state which relatives, type of tumor and age of diagnosis as well as whether they are still alive or not:

**Supplementary notes:**



**IF IT IS POSSIBLE, PLEASE BRING THE MEDICAL REPORTS OF YOUR RELATIVES, FOR CANCER INCLUDING RESULTS OF TUMOR HISTOLOGY!**

I declare that I completed all data truthfully and according to the facts which are known to me.

**Date:**

**Signature:**

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