Family Health History Form

Fill out all pages of this form about you, your partner, and your families.
Read the directions for each section—they contain important information.

MARCH OF DIMES®

Date _____

This form doesn't replace the health history form that you fill out at your healthcare provider's office. You can use it to get started on your family health history. Share the form with your provider—it gives helpful information about health conditions that run in your family. It's OK if you can't answer all the questions on the form.

About you and your partner

	You	Your partner
Name		
Date of birth		
Job		
Marital status (single, married, divorced, widowed)		
Last grade of school completed		
Adopted	○ **Yes** ○ **No**	○ **Yes** ○ **No**

Ethnicity: Put a ✓ in the box or boxes if you or your partner has ancestors from these ethnic backgrounds. This information is important for your provider to be aware of because some diseases, like sickle cell and Tay-Sachs, run in people from certain backgrounds or parts of the world. It's OK to check more than one box.

	You	Your partner
African or African-American	○	○
Ashkenazi Jewish	○	○
Asian/Pacific Islander	○	○
Cajun or French Canadian	○	○
European Caucasian (from England, Germany, Ireland, Switzerland, etc.)	○	○
Hispanic (from Central or South America, Mexico, Puerto Rico, etc.)	○	○
Indian (from India)	○	○
Mediterranean (from Greece, Italy, Turkey, etc.)	○	○
Middle Eastern (from Egypt, Iran, Iraq, Lebanon, etc.)	○	○
Native American	○	○
Southeast Asian (from China, Laos, Vietnam, etc.)	○	○
Other. Please write it here:	○	○
I don't know.	○	○

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Medicines and supplements: List all for you and your partner. Write the name of the medicine or supplement and how often and how much you take. If there are none, write "none." If you don't know, write "don't know."

		What? How often? How much? If there are none, write "none." If you don't know, write "don't know."
Prescription medicine	You	
	Your partner	
Over-the-counter medicine	You	
	Your partner	
Multivitamin, prenatal vitamin, or other supplement	You	
	Your partner	

Harmful substances: List all for you and your partner. Write the name of the substance, and how often and how much you use or are exposed to it. If there are none, write "none." If you don't know, write "don't know."

		What? How often? How much? If there are none, write "none." If you don't know, write "don't know."
Smoking or vaping	You	
	Your partner	
Alcohol (beer, wine, liquor)	You	
	Your partner	
Street drugs (marijuana, cocaine, heroin, ecstacy, etc.)	You	
	Your partner	
Chemicals you use (weed killer, paint, paint thinner, turpentine, etc.)	You	
	Your partner	

Health conditions: Put a ✓ in the "yes," "no," or "don't know" box for any health conditions you, your partner, or your family members have now or have had in the past. In the last column, write the family member who has the condition and which side of the family the person is from. Family members are anyone related to you by blood. Do not include family members who are adopted or part of your step-family.

	Yes	No	Don't know	Tell us as much as you know about the person, such as the relationship to you and the person's age when the condition started.
Example: High blood pressure	☑	○	○	**My dad's sister, 45 years old**
Autism	○	○	○	
Birth defects, including heart defects or spina bifida	○	○	○	
Blindness from birth or before age 40	○	○	○	

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	Yes	No	Don't know	Tell us as much as you know about the person, such as the relationship to you and the person's age when the condition started.
Blood clots or deep vein thrombosis (DVT)	○	○	○	
Cancer, such as breast, ovarian, or colon	○	○	○	
Cystic fibrosis (CF)	○	○	○	
Deafness from birth or before age 40	○	○	○	
Diabetes	○	○	○	
Early menopause (before age 40)	○	○	○	
Heart disease, including heart attack	○	○	○	
Hemophilia	○	○	○	
High blood pressure	○	○	○	
Intellectual disabilities, including Fragile X syndrome or learning disabilities	○	○	○	
Mental illness, such as depression or anxiety	○	○	○	
Preeclampsia	○	○	○	
Pulmonary embolism (PE)	○	○	○	
Repeat pregnancy losses (miscarriage, stillbirth)	○	○	○	
Sickle cell disease	○	○	○	
Spinal muscular atrophy	○	○	○	
Stroke	○	○	○	
Sudden, unexpected death as an adult or child	○	○	○	
Tay-Sachs	○	○	○	
Thalassemia, a type of anemia	○	○	○	
von Willebrand disease	○	○	○	

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If you, your partner or someone in your families has a medical condition that isn't listed above, please write about it here:

Have you or anyone in your family had a preterm baby (born before 37 completed weeks of pregnancy)?
◯ **Yes** ◯ **No** ◯ **Don't know**

Have you, your partner, or anyone in your families had genetic testing? ◯ **Yes** ◯ **No** ◯ **Don't know**
If yes, please explain:

Are you and your partner first cousins or in any other way blood relatives? ◯ **Yes** ◯ **No**
If yes, please explain how you're related:

For more information on family health history, check out these resources:

Does It Run in the Family?
doesitruninthefamily.org or 1-202-966-5557
This online tool helps you create personalized booklets to start conversations about health in your family and community.

Know Your Family Health History
American Society of Human Genetics and Genetic Alliance
talkhealthhistory.org or email info@talkhealthhistory.org
This site has tools and tips to help you talk to your family and your provider about health history.

About March of Dimes

March of Dimes leads the fight for the health of all moms and babies. We support research, lead programs, and provide education and advocacy so that every family can get the best possible start. Building on a successful legacy since 1938, we support every pregnant person and every family.
marchofdimes.org