Family health history

Family history can be considered a sub-area of genealogy. It is based on the patient's data and concerns his **family members'**. Family anamnesis is an integral part of the anamnesis in any field, in clinical genetics its knowledge is absolutely necessary. When evaluating the family history, it is necessary to obtain a comprehensive view of morbidity and mortality in the family in several generations. The data are based on subject's knowledge, who informs about the "family history" with regard to kinship and health problems of individual family members. The reliability of the informant is **limited** by the effect of time, motivation of the proband, unintentional (e.g. loss of contact with relatives, uncertainty in diagnosis, etc.) or even intentional errors (e.g. illegitimacy, adoption, **concealment** of certain data, etc.).

It is desirable to state the family history with age of the **onset** of the disease, the **age of death** of the affected persons, or the age of all individuals listed in the family tree. Data on the types of diseases that occur in the family are recorded. Diseases are divided into multifactorial inherited diseases, monogenic inherited diseases and others. If the same disease occurs repeatedly, it is also necessary to evaluate the immediate consequences of environmental and lifestyle influences. Not all recurrent phenotypic manifestations are genetically determined - they may, for example, be conditioned by the effect of an external influence (phenocopy).

Based on the information obtained, the clinical geneticist can propose a more precise family history - delivery of available objective documentation (**medical reports**), propose additional examinations, genetic analysis, all with the informed consent of the proband and interested family members.

Links

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