FAMILY HISTORY QUESTIONNAIRE

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Family history and the current family situation are no doubt of great clinical importance not only in psychiatry but also in general medicine. The family background often gives cues, though sometimes misleading, to diagnosis, prognosis, drug treatment and rehabilitation. In psychiatric research, Vaughn and Leff (1976) have recently confirmed finding of Brown et al. (1972) that high expressed emotion of the patients' relatives is a good predictor of symptomatic relapse of schizophrenia, and is related to some psychophysiological parameters (Leff (1978)). Johnstone et al. (1979) have found that the social outcome of acute schizophrenics is significantly related to social isolation before admission but not to clinical symptomatology. These research findings illustrate the significance of family and social situations in clinical psychiatry. However, in the purely clinical situation, a detailed family history is difficult to obtain. The clinical guideline of family history taking is well summarized in “Notes on Eliciting and Recording Clinical Information” (The Department of Psychiatry Teaching Committee Institute of Psychiatry London (1973)), as follows:

Mother: age, or age and patient's age at the time of her death, and cause of death. Occupation. Mental physical illnesses; personality. Patient's relationship to her in childhood and subsequently, and reaction to her death. Periods of separation in childhood; duration and circumstances.

Father: data as for Mother. Always record details of his occupation.

Sibs: enumerate in chronological order of birth, with first names, ages, marital state, occupation, significant illnesses, personality. (Include miscarriages and stillbirths.) Patient's previous and current relationship with them.

Other relatives: familial diseases, alcoholism, abnormal personalities, mental disorder, epilepsy (say so if information is lacking). Note the place and time of psychiatric treatment received by members of family.

Family atmosphere in childhood: salient happenings affecting parents and collaterals during patient’s early years. Emotional relationships within the family. Early stresses arising from emotional or economic causes, including death of, or separation from, close relatives, and patient’s age at the time. Mayer-Gross's textbook (Mayer-Gross et al. (1969)) does not go beyond this. More detailed information is by no means unnecessary (Russel-Davis (1978), Endicott et al. (1978)) but clinically less important. The next question which arises is whether all of the questions quoted above are actually asked in the everyday clinical setting. The answer tends to be negative especially in a busy mental hospital and out-patient clinic. Moreover, physicians tend not to write negative data and often use description like "family history nothing particular". What busy psychiatrists need in order to avoid this ambiguity is not a fully detailed questionnaire which is suitable for research purposes but a simple and short reminder.

The family history questionnaire established by the author (see Appendix) may be used as a convenient reminder in busy clinical situation. This need not take a long time to fill in (the author normally spends only five minutes for this though largely depending on the patients’ co-operation). Nurses,

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social workers and other paramedical staff can easily use it. This questionnaire is normally used by
an interviewer and not shown to the interviewer, but it may be used with a slight modification as a
self rating questionnaire, which is time-saving in a busy clinical and research situation. If this is tabu-
lated (which is again quite easy to do) it may be more easily looked though afterwards. Therefore,
when necessary, the data may be put into a computers without any difficulty.

Some distinctive features of this questionnaire are as follows: Firstly, questions are restricted to the
patient’s first degree relatives and spouse(s). This seems fairly sufficient for genetic studies and if the
questions go beyond first degree relatives, the reliability of the data obtained may be greatly reduced.
Secondly, the questions are restricted to purely objective data—dead or alive (if dead, when and why)
age, mental past history (if present, hospital admission) and parental separation for more than 12
months. These data are independent of the mental condition in question (Brown et al. (1977)). In
other words, there is not the slightest possibility that most of these events could have happened as a
result of the present mental condition. Thirdly, other information, whether secondary to the present
illness or not, may be described in the blank space if the interviewer thinks it necessary. Fourthly,
even other people who had not conducted the interview would find it obvious whether particular ques-
tions had been asked or not. This can avoid the frustration which arises when facing description such
as “family history N.P.” in case notes. Finally, when the physician uses the problem oriented recording
system (Ryback (1974)), this questionnaire will compose a part of the patient’s profile.

In addition to these clinical advantages, this questionnaire can be used as a tool in research projects.
Apart from genetic studies, where psychiatric family history is crucial, one can combine these data with
any other clinical and experimental data. For example, in depression, loss of mother in the past is
supposed to be a risk factor (Brown et al., (1978)). In schizophrenia, patients tend to lose their father
before their birth (Huttunen and Nishinen (1978)). It has been said that the higher the maternal age,
the higher the incidence of schizophrenia (Dalén (1977)). If the date of birth of the first degree relatives
is asked, this questionnaire may be used for the study of the seasons of birth of the schizophrenics and
their relatives (Buck and Simpson (1978), Editorial (1978), Shinuura et al. (1977)). In psychogenic
disorders bereavement reaction is a good example (Parkes (1965 a, b)). In child psychiatry, family size
is important in many clinical problems (Rutter and Hersov (1977)).

In short, this family history questionnaire is a time-saving instrument not only in a busy clinical
work but in a variety of research projects.

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APPENDIX

Family History Questionnaire (Part 1)

Name of Patient ____________________
Registration number ____________________
Ward ____________________
Date of interview ____________________
Interviewer ____________________
Informant ____________________

Is your father alive?
Yes, he is alive.
No, he is dead.

If he is alive, how old is he?
He is _____ years old.

If he is dead, when did he die?
In 19 _____
(Or about _____ years ago)

Why did he die?
Because ____________________

How old was he when he died?
He was _____ years old.

When you were younger than 17 years old, did you ever live separately from your father for more than 12 months?
Yes.
No.

If yes, since when, till when, and why?
From ___________ till ___________
Because ____________________

Did your father ever have any type of nervous breakdown?
Yes.
No.

If yes, what, how, and when was it?

Was he admitted to a hospital because of that?
Yes.
No.

If yes, which hospital, when and how long?
(please write down all admissions.)

Family History Questionnaire (Part II)

Is your mother alive?
Yes, she is alive.
No, she is dead.

If she is alive, how old is she?
She is _____ years old.

If she is dead, when did she die?
In 19 _____
(Or about _____ years ago)

Why did she die?
Because

How old was she when she died?

She was _____ years old.

When you were younger than 17 years old, did you ever live separately from your mother for more 12 months?

Yes.

No.

If yes, since when till when and why?

From ______________________ till ______________________

Because ______________________

Did your mother ever have any type of nervous break down?

Yes.

No.

If yes, what, how and when was it?

Was she admitted to a hospital because of that?

Yes.

No.

If yes, which hospital, when and how long?

(please write down all admissions.)

Family History Questionnaire (Part III)

How many brothers and sisters have you now, and if any, how old are they?

<table>
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<tr>
<th>Names</th>
<th>Age</th>
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</tbody>
</table>

Have you any other brothers and sisters who are dead?

Yes.

No.

If yes, please fill in the following blanks.

<table>
<thead>
<tr>
<th>Name</th>
<th>Brother/Sister</th>
<th>Age when died</th>
<th>When was it?</th>
<th>How old were you when he/she died?</th>
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Did anyone alive or dead of your brothers and sisters ever suffer from any type of nervous break down?

Yes.

No.

If yes, who, what, how, and when was it?

Was he/she admitted to a hospital because of that?

Yes.

No.
If yes, which hospital, when, and how long?
(Please write down all admissions.)

Family History Questionnaire (Part IV)
Are you married now?
Married.
Single.
Divorced.
If yes, when did you get married, and how old is your spouse?
In 19 ___,
He/She is _________ years old.
Did you ever lose your spouse by death?
Yes.
No.
If yes, when, why, how old was he/she, and how old were you?
In 19 ___,
Because _____________________
He/She was _________ years old.
I was _________ years old.
Please write down others marriages if any.

Did your spouse ever suffer from any type of nervous break down?
Yes.
No.
If yes, what, how and when was it?

Was he/she admitted to a hospital because of that?
Yes.
No.
If yes, which hospital, when, and how long?
(Please write down all admissions.)

Family History Questionnaire (Part V)
How many children have you now, and if any, how old are they?

<table>
<thead>
<tr>
<th>Names</th>
<th>Boy/Girl</th>
<th>Age</th>
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Have you any others children who are dead?
Yes.
No.
If yes, please fill the following blanks.
Names       Boy/Girl    Age when died   When was it?   How old were you when he/she died?

______________________

______________________

Did anyone alive or dead of your children ever suffer from any type of nervous break down?
   Yes.
   No.
If yes, who, what, who, and when was it?

Was he/she admitted to a hospital because of that?
   Yes.
   No.
If yes, which hospital, when, and how long?
(Please write down all admissions.)

Family History Questionnaire (Part VI)
Did anybody among your relatives whom you have not mentioned above ever suffer from any type of nervous break down?
If so, who, what, how, when, and any hospital admissions?
Please write details here.

Other comments
家族歴調査表

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精神医学における家族歴及び家族情状の重要性は明らかで、最近の諸研究も分裂病において精神病理学的症候により社会情状の方がより良い予後判定要素であることを示唆している。多くの教科書には家族歴調査で問うべき項目について書かれているが、しかし実際臨床においてはすべての必要項目が問われるとはわずか稀で、かつ多くの場合に会う「ネガティブ・データ」は、「家族歴に特記すべきことなし」などといった表現が用いられ、記載されない傾向にある。

今回著者は多忙な実際臨床場面に適した家族歴についての質問を作製した。これは書き込みが短時間（約5分）で済む、医師以外の医療従事者にも簡便で、患者自身が記入する型の質問用紙にも無理なく改変出来、従って電算機に記録することも容易である。質問項目は患者の一親等親族、兄弟姉妹及び配偶者に限られ、内容も問題となっている精神疾患から独立して純粋に客観的事柄になっているが、他の情報も面接者が必要と考えた場合には記入出来る余裕があり、特定の質問がなされたかどうかが後になっても明白にわかり、さらにはいわゆる problem oriented recording system の重要な一部をも構成できるといった点が特徴である。

さらに種々の臨床研究においても短時間で効率よく家族歴を調べる道具として用いられる可能性が高い。