

# Health & Care Information Model:

nl.zorg.FamilyHistory-v5.0

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# Content

<b>1. nl.zorg.FamilyHistory-v5.0</b>	<b>3</b>
1.1 Revision History	3
1.2 Concept	4
1.3 Mindmap	4
1.4 Purpose	4
1.5 Patient Population	4
1.6 Evidence Base	4
1.7 Information Model	4
1.8 Example Instances	8
1.9 Instructions	8
1.10 Interpretation	8
1.11 Care Process	8
1.12 Example of the Instrument	8
1.13 Constraints	8
1.14 Issues	8
1.15 References	9
1.16 Functional Model	9
1.17 Traceability to other Standards	9
1.18 Disclaimer	9
1.19 Terms of Use	9
1.20 Copyrights	9

# 1. nl.zorg.FamilyHistory-v5.0

DCM::CoderList	Kerngroep Registratie aan de Bron
DCM::ContactInformation.Address	*
DCM::ContactInformation.Name	*
DCM::ContactInformation.Telecom	*
DCM::ContentAuthorList	Projectgroep Generieke Overdrachtsgegevens & Kerngroep Registratie aan de Bron
DCM::CreationDate	15-02-2013
DCM::DeprecatedDate	
DCM::DescriptionLanguage	nl
DCM::EndorsingAuthority.Address	
DCM::EndorsingAuthority.Name	PM
DCM::EndorsingAuthority.Telecom	
DCM::Id	2.16.840.1.113883.2.4.3.11.60.40.3.6.1
DCM::KeywordList	familieanamnese, anamnese
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DCM::Supersedes	nl.zorg.Familieanamnese-v4.0
DCM::Version	5.0
HCIM::PublicationLanguage	EN

## 1.1 Revision History

Publicatieversie 1.0 (15-02-2013)

Publicatieversie 1.1 (01-07-2013)

Publicatieversie 2.0 (01-04-2015)

Bevat: ZIB-73, ZIB-308.

Incl. algemene wijzigingsverzoeken:

ZIB-94, ZIB-154, ZIB-200, ZIB-201, ZIB-309, ZIB-324, ZIB-326.

Publicatieversie 3.0 (01-05-2016)

Bevat: ZIB-444, ZIB-453.

Publicatieversie 3.1 (04-09-2017)

Bevat: ZIB-443, ZIB-564, ZIB-574.

Publicatieversie 3.2 (01-12-2021)

Bevat: ZIB-1303.

Publicatieversie 3.2.1 (10-06-2022)

Bevat: ZIB-1671

Publicatieversie 3.2.2 (15-10-2023)

Bevat: ZIB-2026.

1.2 Concept

The family history describes any health problems of biological relatives that may be relevant. The family history contains information on the medical disorders of the family member and the biological relationship between the patient and the described family member.

1.3 Mindmap

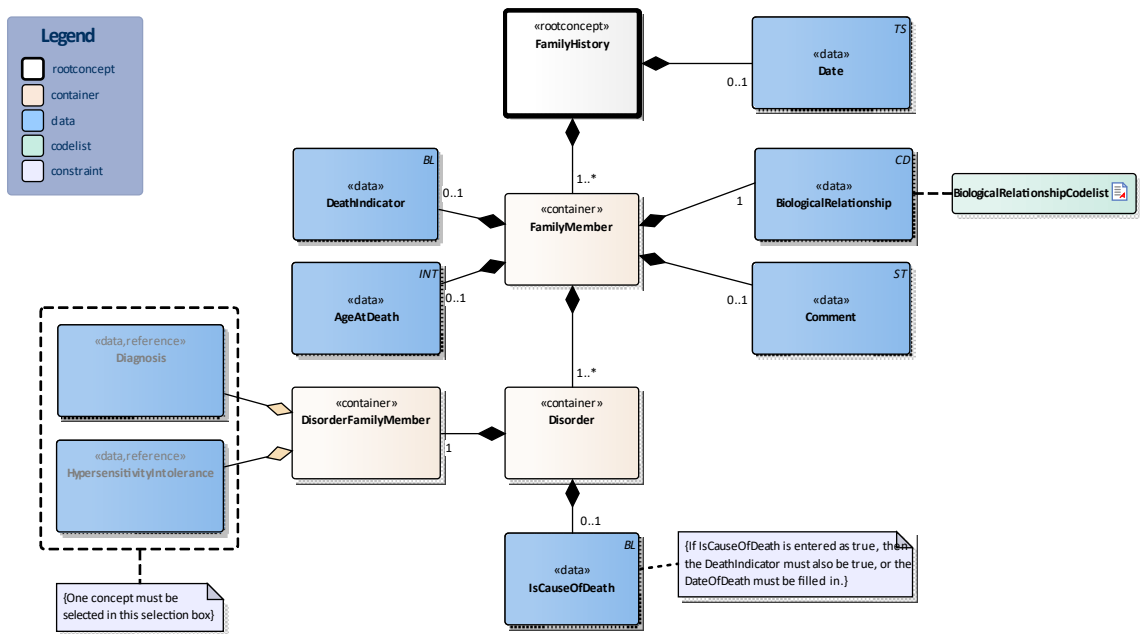
1.4 Purpose

Recording the patient’s family members’ disorders. This component can be relevant in estimating the risk of these disorders occurring in the patient. This component can also partially influence the decision determining which diagnostics are or are not to be run: a high-risk patient might be more likely to receive extensive diagnostics, while a simpler test could suffice for a low-risk patient.

1.5 Patient Population

1.6 Evidence Base

1.7 Information Model



«rootconcept»	FamilyHistory
Definitie	Root concept of the FamilyHistory information model. This root concept

	contains all data elements of the FamilyHistory information model.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:6.1.1	
<b>Opties</b>		

<b>«data»</b>	<b>Date</b>	
<b>Definitie</b>	Date on which the family history was entered. A 'vague' date is permitted.	
<b>Datatype</b>	TS	
<b>DCM::ConceptId</b>	NL-CM:6.1.2	
<b>DCM::ExampleValue</b>	3-1999	
<b>Opties</b>		

<b>«container»</b>	<b>FamilyMember</b>	
<b>Definitie</b>	Container of the FamilyMember concept. This container contains all data elements of the FamilyMember concept.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:6.1.3	
<b>Opties</b>		

<b>«data»</b>	<b>BiologicalRelationship</b>	
<b>Definitie</b>	Indicates the biological relationship of the family member to the patient.	
<b>Datatype</b>	CD	
<b>DCM::ConceptId</b>	NL-CM:6.1.4	
<b>DCM::ExampleValue</b>	Broer	
<b>DCM::ValueSet</b>	BiologicalRelationshipCodeList	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.6.1.1
<b>Opties</b>		

<b>«data»</b>	<b>Comment</b>	
<b>Definitie</b>	Comment with information on the family member which might be relevant to the family history.	
<b>Datatype</b>	ST	
<b>DCM::ConceptId</b>	NL-CM:6.1.5	
<b>DCM::DefinitionCode</b>	LOINC: 48767-8 Annotation comment	
<b>Opties</b>		

<b>«container»</b>	<b>Disorder</b>	
<b>Definitie</b>	Container of the Disorder concept. This container contains all data elements of the Disorder concept.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:6.1.6	
<b>Opties</b>		

<b>«data»</b>	<b>IsCauseOfDeath</b>	
<b>Definitie</b>	Indication stating whether the described health problem was the cause of death of the family member.	
<b>Datatype</b>	BL	
<b>DCM::ConceptId</b>	NL-CM:6.1.9	
<b>Opties</b>		

<b>«container»</b>	<b>DisorderFamilyMember</b>	
<b>Definitie</b>	Container of the DisorderFamilyMember concept. This container contains all data elements of the DisorderFamilyMember concept.	

<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:6.1.13	
<b>Opties</b>		

<b>«data»</b>	<b>Diagnosis</b>	
<b>Definitie</b>	Diagnosis of a condition in a blood relative of the patient.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:6.1.14	
<b>DCM::ReferencedConceptId</b>	NL-CM:5.6.1	This is a reference to the rootconcept of information model Diagnosis.
<b>Opties</b>		

<b>«data»</b>	<b>HypersensitivityIntolerance</b>	
<b>Definitie</b>	Hypersensitivity or intolerance in a blood relative of the patient.	
<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:6.1.15	
<b>DCM::ReferencedConceptId</b>	NL-CM:8.6.1	This is a reference to the rootconcept of information model HypersensitivityIntolerance.
<b>Opties</b>		

<b>«data»</b>	<b>AgeAtDeath</b>	
<b>Definitie</b>	The age at which the family member died.	
<b>Datatype</b>	INT	
<b>DCM::ConceptId</b>	NL-CM:6.1.12	
<b>DCM::ExampleValue</b>	75	
<b>Opties</b>		

<b>«data»</b>	<b>DeathIndicator</b>	
<b>Definitie</b>	An indication stating whether the family member has died.	
<b>Datatype</b>	BL	
<b>DCM::ConceptId</b>	NL-CM:6.1.10	
<b>DCM::ExampleValue</b>	Ja	
<b>Opties</b>		

<b>«document»</b>	<b>BiologicalRelationshipCodelist</b>	
<b>Definitie</b>		
<b>Datatype</b>		
<b>DCM::ValueSetBinding</b>	Extensible	
<b>DCM::ValueSetId</b>	2.16.840.1.113883.2.4.3.11.60.40.2.6.1.1	
<b>DCM::ValueSetIncludeOTH</b>	True	
<b>DCM::ValueSetStatus</b>	Active	
<b>HCIM::ValueSetLanguage</b>	EN	
<b>Opties</b>		

BiologischeRelatieCodelijst			OID: 2.16.840.1.113883.2.4.3.11.60.40.2.6.1.1	
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Aunt	AUNT	RoleCode	2.16.840.1.113883.5.111	Tante
Cousin	COUSN	RoleCode	2.16.840.1.113883.5.111	Neef/nicht, zoon/dochter van oom/tante
Grandchild	GRNDCHILD	RoleCode	2.16.840.1.113883.5.111	Kleinkind(DEPRECATED)

Granddaughter	GRNDDAU	RoleCode	2.16.840.1.113883.5.111	Kleindochter
Grandfather	GRFTH	RoleCode	2.16.840.1.113883.5.111	Opa
Grandmother	GRMTH	RoleCode	2.16.840.1.113883.5.111	Oma
Grandparent	GRPRN	RoleCode	2.16.840.1.113883.5.111	Grootouder (DEPRECATED)
Grandson	GRNDSO	RoleCode	2.16.840.1.113883.5.111	Kleinzoon
Great grandfather	GGRFTH	RoleCode	2.16.840.1.113883.5.111	Overgrootvader
Great grandmother	GGRMTH	RoleCode	2.16.840.1.113883.5.111	Overgrootmoeder
Great grandparent	GGRPRN	RoleCode	2.16.840.1.113883.5.111	Overgrootouder
Half-brother	HBRO	RoleCode	2.16.840.1.113883.5.111	Halfbroer
Half-sister	HSIS	RoleCode	2.16.840.1.113883.5.111	Halfzus
Maternal female first cousin	134211000146103	SNOMED CT	2.16.840.1.113883.6.96	Nicht aan moederszijde
Maternal grandfather	MGRFTH	RoleCode	2.16.840.1.113883.5.111	Opa aan moederszijde
Maternal grandmother	MGRMTH	RoleCode	2.16.840.1.113883.5.111	Oma aan moederszijde
Maternal great-grandfather	MGGRFTH	RoleCode	2.16.840.1.113883.5.111	Overgrootvader aan moederszijde
Maternal great-grandmother	MGGRMTH	RoleCode	2.16.840.1.113883.5.111	Overgrootmoeder aan moederszijde
Maternal male first cousin	134221000146108	SNOMED CT	2.16.840.1.113883.6.96	Neef aan moederszijde
MaternalAunt	MAUNT	RoleCode	2.16.840.1.113883.5.111	Tante/moederszijde
MaternalCousin	MCOUSN	RoleCode	2.16.840.1.113883.5.111	Neef/nicht aan moederszijde
MaternalGrandparent	MGRPRN	RoleCode	2.16.840.1.113883.5.111	Grootouder aan moederszijde
MaternalGreatgrandparent	MGGRPRN	RoleCode	2.16.840.1.113883.5.111	Overgrootouder aan moederszijde
MaternalUncle	MUNCLE	RoleCode	2.16.840.1.113883.5.111	Oom/moederszijde
Natural brother	NBRO	RoleCode	2.16.840.1.113883.5.111	Biologische broer
Natural child	NCHILD	RoleCode	2.16.840.1.113883.5.111	Biologisch kind
Natural daughter	DAU	RoleCode	2.16.840.1.113883.5.111	Biologische dochter
Natural father	NFTH	RoleCode	2.16.840.1.113883.5.111	Biologische vader
Natural mother	NMTH	RoleCode	2.16.840.1.113883.5.111	Biologische moeder
Natural sister	NSIS	RoleCode	2.16.840.1.113883.5.111	Biologische zus
Natural son	SON	RoleCode	2.16.840.1.113883.5.111	Biologische zoon
Nephew	NEPHEW	RoleCode	2.16.840.1.113883.5.111	Neef, zoon van broer/zus
Niece	NIECE	RoleCode	2.16.840.1.113883.5.111	Nicht, dochter van broer/zus
Paternal female first cousin	134231000146105	SNOMED CT	2.16.840.1.113883.6.96	Nicht aan vaderszijde
Paternal grandfather	PGRFTH	RoleCode	2.16.840.1.113883.5.111	Opa aan vaderszijde
Paternal grandmother	PGRMTH	RoleCode	2.16.840.1.113883.5.111	Oma aan vaderszijde
Paternal great-grandfather	PGGRFTH	RoleCode	2.16.840.1.113883.5.111	Overgrootvader aan vaderszijde
Paternal great-grandmother	PGGRMTH	RoleCode	2.16.840.1.113883.5.111	Overgrootmoeder aan vaderszijde
Paternal male first cousin	134241000146102	SNOMED CT	2.16.840.1.113883.6.96	Neef aan vaderszijde
PaternalAunt	PAUNT	RoleCode	2.16.840.1.113883.5.111	Tante/vaderszijde
PaternalCousin	PCOUSN	RoleCode	2.16.840.1.113883.5.111	Neef/nicht aan vaderszijde
PaternalGrandparent	PGRPRN	RoleCode	2.16.840.1.113883.5.111	Grootouder aan vaderszijde
PaternalGreatgrandparent	PGGRPRN	RoleCode	2.16.840.1.113883.5.111	Overgrootouder aan vaderszijde

PaternalUncle	PUNCLE	RoleCode	2.16.840.1.113883.5.111	Oom/vaderszijde
Uncle	UNCLE	RoleCode	2.16.840.1.113883.5.111	Oom

	Legend
Definitie	
Datatype	
Opties	

	Constraint
Definitie	One concept must be selected in this selection box
Datatype	
Opties	

## 1.8 Example Instances

Familieanamnese							
Datum	Familielid				Aandoening		
	BiologischeRelatie	Toelichting	OverlijdensIndicator	OverlijdensDatum	AandoeningFamilielid		Is Doodsoorzaak
1-2-2013	Tante / moederszijde		Ja	1997	Diagnose	mammacarcinoom	Ja
1-2-2013	Biologische moeder	moeder heeft vijf zusters			Diagnose	mammacarcinoom	
1-2-2013	Biologische vader		Ja	2005	OvergevoeligheidIntolerantie	Penicillineovergevoeligheid	

## 1.9 Instructions

The age at which a family member developed a disorder or the age at which the family member died can be included in the 'explanation' field if desired.

The value list *BiologicalRelationshipCodeList* contains a number of concepts which can be used for both biological and non-biological relatives: a step-father's brother can be listed as an uncle for lack of specific codes for step-uncle and real uncles. Therefore, when compiling the family history, make sure that only the biological relatives are considered.

## 1.10 Interpretation

### 1.11 Care Process

### 1.12 Example of the Instrument

### 1.13 Constraints

### 1.14 Issues



## 1.15 References

## 1.16 Functional Model

## 1.17 Traceability to other Standards

## 1.18 Disclaimer

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