

# Health & Care Information Model:

## nl.zorg.FamilyHistory-v3.2.2

Status: Final

Release status: Prepublished

# Content

<b>1. nl.zorg.FamilyHistory-v3.2.2 .....</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.....	7
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 .....	8
1.16 Functional Model .....	8
1.17 Traceability to other Standards.....	8
1.18 Disclaimer .....	8
1.19 Terms of Use .....	9
1.20 Copyrights .....	9

# 1. nl.zorg.FamilyHistory-v3.2.2

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
DCM::LifecycleStatus	Final
DCM::ModelerList	Kerngroep Registratie aan de Bron
DCM::Name	nl.zorg.Familieanamnese
DCM::PublicationDate	15-10-2023
DCM::PublicationStatus	Prepublished
DCM::ReviewerList	Projectgroep Generieke Overdrachtsgegevens & Kerngroep Registratie aan de Bron
DCM::RevisionDate	11-09-2023
DCM::Supersedes	nl.zorg.Familieanamnese-v3.2.1
DCM::Version	3.2.2
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

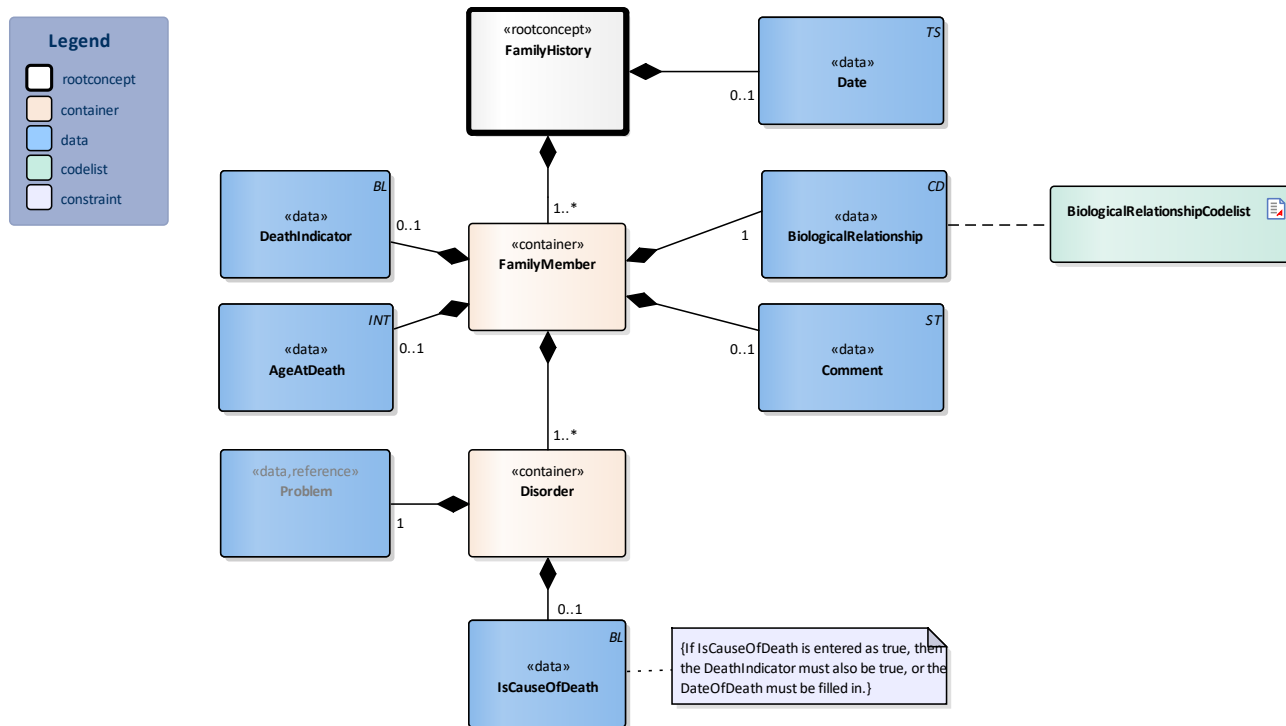
### 1.4 Purpose

Recording the patient’s family members’ health problems. This component can be relevant in estimating the risk of these health problems 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



<b>«rootconcept»</b>	<b>FamilyHistory</b>
<b>Definitie</b>	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>	BiologicalRelationshipCodelis t	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>«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>«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>«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>Problem</b>	
<b>Definitie</b>	The health problem of the family member in question, which is recorded for the family history.	

<b>Datatype</b>		
<b>DCM::ConceptId</b>	NL-CM:6.1.7	
<b>DCM::ReferencedConceptId</b>	NL-CM:5.1.1	This is a reference to the rootconcept of information model Probleem.
<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>«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>HCIM::ValueSetLanguage</b>	EN	
<b>Opties</b>		

<b>BiologischeRelatieCodelijst</b>			<b>OID: 2.16.840.1.113883.2.4.3.11.60.40.2.6.1.1</b>	
<b>Concept Name</b>	<b>Concept Code</b>	<b>Coding Syst. Name</b>	<b>Coding System OID</b>	<b>Description</b>
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	GRNDSON	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	
<b>Definitie</b>	
<b>Datatype</b>	
<b>Opties</b>	

## 1.8 Example Instances

Familieanamnese								
Datum	Familieid				Aandoening			
	Biologische Relatie	Toelichting	Overlijdens Indicator	Overlijdens Datum	Probleem			Is Doodsoorzaak
					ProbleemType	ProbleemNaam	Probleem Status	
1-2-2013	Tante / moeders-zijde		Ja	1997	Diagnose	mammacarcinoom	Actueel	Ja
1-2-2013	Biologische moeder	moeder heeft vijf zusters			Diagnose	mammacarcinoom	Actueel	
1-2-2013	Biologische vader		Ja	2005	Diagnose	myocardinfarct	Niet actueel	

## 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

The Health and Care Information Models (a.k.a Clinical Building Block) has been made in collaboration with several different parties in healthcare. These parties asked Nictiz to manage good maintenance and



development of the information models. Hereafter, these parties and Nictiz are referred to as the collaborating parties. The collaborating parties paid utmost attention to the reliability and topicality of the data in these Health and Care Information Models. Omissions and inaccuracies may however occur. The collaborating parties are not liable for any damages resulting from omissions or inaccuracies in the information provided, nor are they liable for damages resulting from problems caused by or inherent to distributing information on the internet, such as malfunctions, interruptions, errors or delays in information or services provide by the parties to you or by you to the parties via a website or via e-mail, or any other digital means. The collaborating parties will also not accept liability for any damages resulting from the use of data, advice or ideas provided by or on behalf of the parties by means of the Health and Care Information Models. The parties will not accept any liability for the content of information in this Health and Care Information Model to which or from which a hyperlink is referred. In the event of contradictions in mentioned Health and Care Information Model documents and files, the most recent and highest version of the listed order in the revisions will indicate the priority of the documents in question. If information included in the digital version of a Health and Care Information Model is also distributed in writing, the written version will be leading in case of textual differences. This will apply if both have the same version number and date. A definitive version has priority over a draft version. A revised version has priority over previous versions.

## **1.19 Terms of Use**

The user may use the Health and Care Information Models without limitations. The copyright provisions in the paragraph concerned apply to copying, distributing and passing on the Health and Care Information Models.

## **1.20 Copyrights**

A Health and Care Information Model qualifies as a work within the meaning of Section 10 of the Copyright Act (Auteurswet). Copyrights protect the Health and Care Information Models and these rights are owned by the cooperating parties.

The user may copy, distribute and pass on the information in this Health and Care Information Model under the conditions that apply for Creative Commons license Attribution-NonCommercial-ShareAlike 3.0 Netherlands (CC BY-NC-SA-3.0).

The content is available under Creative Commons Attribution-NonCommercial-ShareAlike 3.0 (see also <http://creativecommons.org/licenses/by-nc-sa/3.0/nl/>)

This does not apply to information from third parties that sometimes is used and / or referred to in a Health and Care Information Model, for example to an international medical terminology system. Any (copyright) rights that protect this information are not owned by the cooperating parties but by those third parties.