Health & Care Information Model:

nl.zorg.FamilyHistory-v3.1

Status:Final
Release:2018
Release status: Prepublished

Managed by:

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1. nl.zorg.FamilyHistory-v3.1

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	01-10-2018
DCM::PublicationStatus	Prepublished
DCM::ReviewerList	Projectgroep Generieke Overdrachtsgegevens & Kerngroep Registratie aan de Bron
DCM::RevisionDate	31-12-2017
DCM::Superseeds	nl.zorg.Familieanamnese-v3.0
DCM::Version	3.1
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.

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

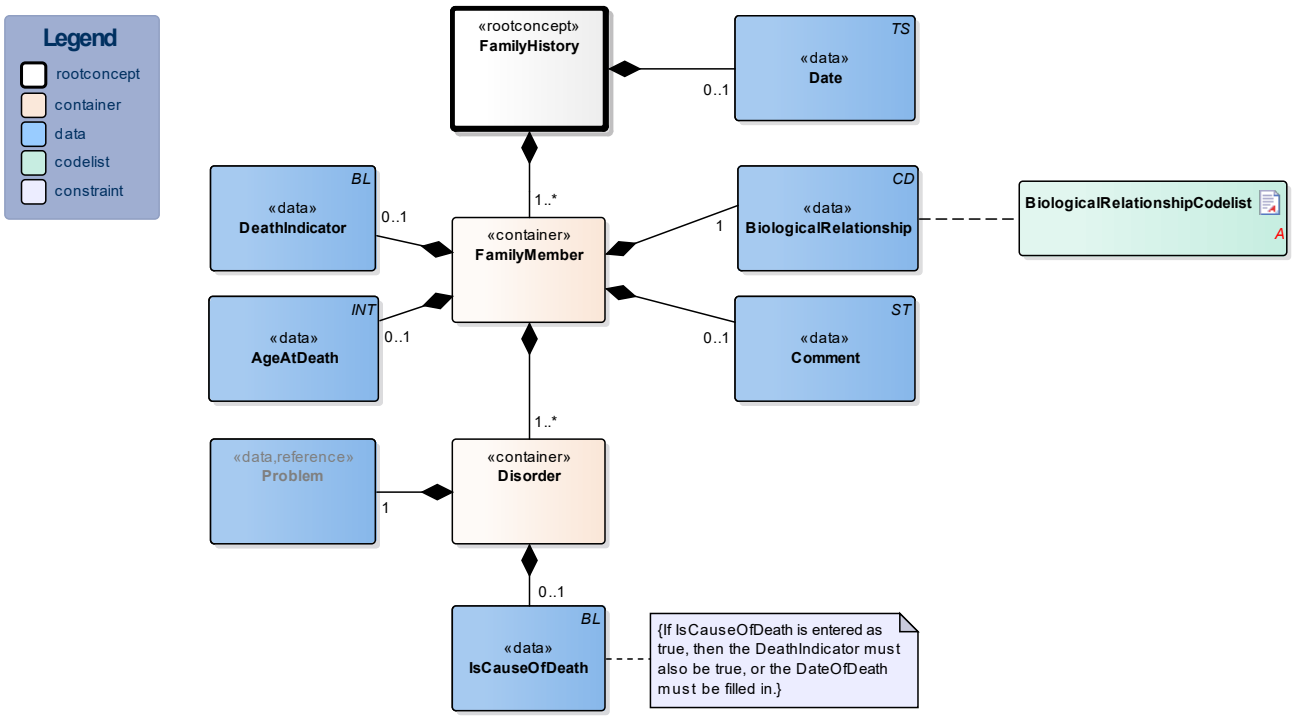
1.4 Purpose

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



«rootconcept»	FamilyHistory	
Definitie	Root concept of the FamilyHistory information model. This root concept contains all data elements of the FamilyHistory information model.	
Datatype		
DCM::ConceptId	NL-CM:6.1.1	
Opties		

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

Opties	

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

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

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

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

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

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

«data»	Problem	
Definitie	The health problem of the family member in question, which is recorded for the family history.	
Datatype		
DCM::ConceptId	NL-CM:6.1.7	
DCM::ReferencedConceptId	NL-CM:5.1.1	This is a reference to the rootconcept of information model Probleem.
Opties		

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

«document»	BiologicalRelationshipCodelist	
Definitie		
Datatype		
DCM::ValueSetBinding	Extensible	
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.6.1.1	
Opties		

BiologischeRelatieCodelijst			**OID: 2.16.840.1.113883.2.4.3.11.60.40.2.6.1.1**	
Concept Name	**Code**	**Code System**	**Code 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
Grandparent	GRPRN	RoleCode	2.16.840.1.113883.5.111	Grootouder
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
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	Gootouder 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 child	NCHILD	RoleCode	2.16.840.1.113883.5.111	Biologisch kind
Natural daugther	DAU	RoleCode	2.16.840.1.113883.5.111	Biologische dochter

Natural son	SON	RoleCode	2.16.840.1.113883.5.111	Biologische zoon
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 brother	NBRO	RoleCode	2.16.840.1.113883.5.111	Biologische broer
Natural sister	NSIS	RoleCode	2.16.840.1.113883.5.111	Biologische zus
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
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

1.8 Example Instances

Familieanamnese									
Datum	Familielid				Aandoening				
	Biologische Relatie	Toelichting	Overlijdens Indicator	Overlijdens Datum	Probleem				Is Doodsoorzaak
					ProbleemType	ProbleemNaam	Probleem Status	Probleem StatusDatum	
1-2-2013	Tante / moeders-zijde		Ja	1997	Diagnose	mammacarcinoom	Actueel	1995	Ja
1-2-2013	Biologische moeder	moeder heeft vijf zusters			Diagnose	mammacarcinoom	Actueel	21-3-1999	
1-2-2013	Biologische vader		Ja	2005	Diagnose	myocardinfarct	Niet actueel	16-6-2001	

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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