Lawrenceville Pediatrics, P.D.
Lawrenceville Highway, Lawrenceville, GA
30045
ID#58-1575002

Family History Questionnaire

Patient's Name_____ Date of Birth_____

Date of Visit _____Person Filling out Questionnaire_____

Are there any relatives in your child's family (siblings, parents, grandparents, aunts, uncles, cousins, or other family members) with a history of any of the following conditions?

	Yes	No	
Diabetes	☐	☐	If yes, who? _____
Heart Disease	☐	☐	If yes, who? _____
High Blood Pressure	☐	☐	If yes, who? _____
High Cholesterol	☐	☐	If yes, who? _____
Stroke	☐	☐	If yes, who? _____
Cancer	☐	☐	If yes, who? _____
			If yes, what kind? _____
Kidney Disease	☐	☐	If yes, who? _____
Liver Disease	☐	☐	If yes, who? _____
Eye Disease	☐	☐	If yes, who? _____
Depression	☐	☐	If yes, who? _____
Epilepsy	☐	☐	If yes, who? _____
Asthma	☐	☐	If yes, who? _____
Eczema/Allergies	☐	☐	If yes, who? _____
Anemia/Blood Disease	☐	☐	If yes, who? _____
Thyroid Disease	☐	☐	If yes, who? _____
Drug/Alcohol	☐	☐	If yes, who? _____
Ear/Hearing Problems	☐	☐	If yes, who? _____
Genetic Conditions	☐	☐	If yes, who? _____
GI Problems	☐	☐	If yes, who? _____

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