Lawrenceville Pediatrics, P.C.
980 Lawrenceville Highway, Lawrenceville, Ga. 30045
Tax 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?

Diabetes	Yes/No	If yes, who? _____
Heart Disease	Yes/No	If yes, who? _____
High Blood Pressure	Yes/No	If yes, who? _____
High Cholesterol	Yes/No	If yes, who? _____
Strokes	Yes/No	If yes, who? _____
Cancer	Yes/No	If yes, who? _____
		If yes, what kind? _____
Kidney Disease	Yes/No	If yes, who? _____
Liver Disease	Yes/No	If yes, who? _____
Eye Disease	Yes/No	If yes, who? _____
Depression	Yes/No	If yes, who? _____
Epilepsy	Yes/No	If yes, who? _____
Asthma	Yes/No	If yes, who? _____
Eczema/Allergies	Yes/No	If yes, who? _____
Anemia/Blood Disease	Yes/No	If yes, who? _____
Thyroid Disease	Yes/No	If yes, who? _____
Drug/Alcohol	Yes/No	

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