



Pediatric Associates

of Kershaw County, PA

(803) 432-1931

Name:
Chart Number:
Date:

Family History Questionnaire

Please circle yes or no to all questions.

If yes please explain what family member.

Has anyone in the patient's family (mother, father, grandmother, grandfather, sibling, etc.) ever been diagnosed with any of the following health conditions:

1. Asthma? Yes or NO : If yes; family member _____
 2. Cancer? Yes or NO : If yes; family member _____
 3. Diabetes: Yes or NO : If yes; family member _____
 4. Heart Disease? Yes or NO : If yes; family member _____
 5. Heart Murmur? Yes or NO : If yes; family member _____
 6. High Blood Pressure? Yes or NO : If yes; family member _____
 7. High Cholesterol? Yes or NO : If yes; family member _____
 8. Kidney Disease? Yes or NO : If yes; family member _____
 9. Seizures? Yes or NO : If yes; family member _____
 10. Sickle Cell? Yes or NO : If yes; family member _____
 11. Depression, Anxiety, Bipolar, ADHD, Autism ? Yes or NO : If yes, list family member and which problem: _____
 12. Early Death(less than 50)? Yes or NO : If yes; family member _____
 13. Early Heart Attack (less than 50)? Yes or NO : If yes; family member _____
- Any other health issues? _____

Please check this box if: you have completed this form previously and the history is unchanged.