(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.