Family History Questionnaire

Patient Name: _____ **Date:** _____

Family History

Does, or did anyone in your families (you, your children, parents, grandparents, siblings, aunt, or uncle), or any children from other marriages have, or died from:

	AIDS/HIV or other immune deficiency disease		High cholesterol, triglycerides, lipids
	Alcoholism		Intestinal problems, ulcer, colitis
	Allergies, asthma, hay fever		Kidney disease (stone etc.)
	Anemia, blood problems		Liver disease (hepatitis etc.)
	Arthritis, (lupus, juvenile arthritis, gout, etc.)		Lung disease, cystic fibrosis, tuberculosis
	Babies with SIDS, congenital heart disease		Migraine or severe headaches
	Bleeding problems		Muscle or nerve disease
	Cancer or leukemia		Psychiatric illness
	Celiac disease		Scoliosis, bone problems
	Diabetes (less than age 30)		Seizures, convulsions, retardation
	Genetic problems (Tay Sachs, Down's, etc.)		Skin disease (psoriasis, eczema, etc.)
	Hearing/Vision problems (other than glasses)		Testicular, ovarian or uterine problems
	Heart attack or stroke (less than age 60)		Hip dysplasia:
	High Blood Pressure (Hypertension)		Other illness:

Does anyone smoke in the house? Yes ☐ No ☐ Who?_____