Family History Questionnaire

Please indicate "yes", "no" or "unknown" for the following items.

If YES, please state which family member and if on mom or dad's side.

Include parent and grandparent information only.

Does your child have a family history of:

High Cholesterol	Yes	No	Unknown	_____
High Triglycerides	Yes	No	Unknown	_____
Stroke	Yes	No	Unknown	_____
Diabetes	Yes	No	Unknown	_____
High Blood Pressure	Yes	No	Unknown	_____
Overweight	Yes	No	Unknown	_____
Heart Disease before age 55	Yes	No	Unknown	_____
Acanthosis Nigricans	Yes	No	Unknown	_____

Child's Name _____

Sibling (s) _____

_____

Parents Signature _____ Date _____

12/21/2022