ATHENA FAMILY MEDICINE

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Kevin Vo, MD
Board Certified
Family Medicine

Name: _____ Date of birth: _____ Today's date: _____

ADULT COMPREHENSIVE HISTORY

Your answers help Dr. Vo get an accurate picture of your health. Please complete all pages. It is long because it is thorough, and we want to know you well so we can care for you properly. If you can't remember details, your best guess is fine. If you are uncomfortable with any question, you may skip it. Thank you!

YOUR VISIT

Who referred you to our practice? ☐ Patient ☐ Family member ☐ Another doctor ☐ Insurance ☐ Online search ☐ Other
Name: _____

Main reason for today's visit _____

Your health goals for the next year _____

How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Other doctors you see regularly, and their specialty _____

Medical suppliers you use (for example, oxygen or diabetes supplies) _____

MEDICATIONS

List **all** prescription and non-prescription medications, including vitamins, herbs, supplements, birth control, inhalers and over-the-counter pain relievers (Advil, Aleve, Tylenol, etc.). You may also bring your own printed list.

☐ I do not take any prescription or over-the-counter medications.
☐ I brought a list of my medications (give it to the medical assistant).

Medication	Dose (e.g. mg per pill)	How many times per day?

ALLERGIES

Allergies or reactions to medications? ☐ None

If yes, to what, and what happened? _____

IMMUNIZATIONS

Enter the year of your most recent dose, if known.

Tetanus (Td or Tdap) _____ Flu shot _____ COVID-19 _____

Pneumonia (Prevnar or Pneumovax) _____ Shingles (Shingrix) _____ RSV _____

Hepatitis A _____ Hepatitis B _____ MMR _____

Chickenpox (vaccine or had illness) _____ HPV _____ Meningitis _____

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SCREENING TESTS

Test	Most recent date	Where	Abnormal?
Cholesterol (lipid panel)			☐ No ☐ Yes
Colon cancer screening: ☐ Colonoscopy ☐ Stool test (e.g. Cologuard) ☐ Sigmoidoscopy Polyps found? ☐ No ☐ Yes			☐ No ☐ Yes
Women: Mammogram			☐ No ☐ Yes
Women: Pap smear / HPV test			☐ No ☐ Yes
Bone density (DEXA)			☐ No ☐ Yes

PERSONAL MEDICAL HISTORY

Do you have now, or have you had in the past, any of these conditions?

Condition	Now	Past
Alcohol or drug use problem	☐	☐
Allergies (hay fever)	☐	☐
Anemia	☐	☐
Anxiety	☐	☐
Arthritis (rheumatoid)	☐	☐
Arthritis (osteoarthritis)	☐	☐
Asthma	☐	☐
Bladder or kidney problems	☐	☐
Blood clot (leg)	☐	☐
Blood clot (lung)	☐	☐
Blood transfusion	☐	☐
Breast lump (benign)	☐	☐
Cancer: breast	☐	☐
Cancer: colon	☐	☐
Cancer: ovarian	☐	☐
Cancer: prostate	☐	☐
Cancer: other type	☐	☐
Cataracts	☐	☐
Chickenpox	☐	☐
Colon polyp	☐	☐
Coronary artery disease	☐	☐
Depression	☐	☐
Diabetes (type 1)	☐	☐
Diabetes (type 2)	☐	☐
Diverticulosis	☐	☐
Emphysema / COPD	☐	☐
Fractures (broken bones)	☐	☐
Gallbladder disease	☐	☐
Reflux / heartburn (GERD)	☐	☐
Glaucoma	☐	☐

Condition	Now	Past
Gout	☐	☐
Gynecologic: endometriosis	☐	☐
Gynecologic: fibroids	☐	☐
Gynecologic: other	☐	☐
Heart attack	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
High blood pressure	☐	☐
High cholesterol	☐	☐
Hip fracture	☐	☐
Irritable bowel syndrome	☐	☐
Kidney disease / failure	☐	☐
Kidney stones	☐	☐
Liver disease	☐	☐
Migraine headaches	☐	☐
Osteoporosis	☐	☐
Pneumonia	☐	☐
Prostate enlargement	☐	☐
Seizures / epilepsy	☐	☐
Skin: eczema	☐	☐
Skin: psoriasis	☐	☐
Skin: abnormal moles	☐	☐
Sleep apnea	☐	☐
Stomach ulcer	☐	☐
Stroke	☐	☐
Thyroid nodule	☐	☐
Thyroid: overactive (hyper)	☐	☐
Thyroid: underactive (hypo)	☐	☐

Other conditions or comments (for example, where a fracture was) _____

☐ I have no history of significant medical illness.

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SURGERIES AND PROCEDURES

Check any you have had and the year. List abnormal findings or complications under comments.

Procedure	Yes	Year
Abdominal surgery	☐	
Angiogram (heart)	☐	
Angiogram (blood vessels)	☐	
Appendectomy	☐	
Back surgery (lumbar)	☐	
Biopsy (where: _____)	☐	
Breast biopsy: ☐ R ☐ L ☐ Both	☐	
Breast surgery: ☐ R ☐ L ☐ Both	☐	
Cataract surgery	☐	
Colonoscopy	☐	
Coronary bypass	☐	
Coronary stent	☐	
C-section	☐	
Echocardiogram (heart)	☐	
EGD (stomach scope)	☐	

Procedure	Yes	Year
Gallbladder removal	☐	
Heart surgery (other than bypass)	☐	
Hip surgery: ☐ R ☐ L ☐ Both	☐	
Hysterectomy, partial (ovaries left)	☐	
Hysterectomy, total (ovaries removed)	☐	
Knee surgery: ☐ R ☐ L ☐ Both	☐	
LEEP (cervix procedure)	☐	
Neck (spine) surgery	☐	
Ovary removal: ☐ R ☐ L ☐ Both	☐	
Pulmonary function test	☐	
Sinus surgery	☐	
Stress test (any type)	☐	
Tonsillectomy	☐	
Tubal ligation	☐	
Vasectomy	☐	

Other procedures, comments or complications _____

☐ I have never had any surgeries or procedures.

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FAMILY HISTORY

Were you adopted? ☐ No ☐ Yes If you were adopted and do not know your family history, skip to the next page.

Check which relatives have had each condition. Parents, brothers and sisters are the most important.

	Mother	Father	Sister(s)	Brother(s)	Mom's mom	Mom's dad	Dad's mom	Dad's dad	Other relative (who?)	Age at diagnosis / cause of death?
Living (✓) or deceased (✗)										
Current age or age at death										
No significant history known	☐	☐	☐	☐	☐	☐	☐	☐		
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐		
High cholesterol	☐	☐	☐	☐	☐	☐	☐	☐		
Heart attack / angina	☐	☐	☐	☐	☐	☐	☐	☐		
Heart failure (CHF)	☐	☐	☐	☐	☐	☐	☐	☐		
Heart disease, other	☐	☐	☐	☐	☐	☐	☐	☐		
Sudden cardiac death	☐	☐	☐	☐	☐	☐	☐	☐		
Stroke	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes type 1	☐	☐	☐	☐	☐	☐	☐	☐		
Diabetes type 2	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: breast	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: colon	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: lung	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: ovarian	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: prostate	☐	☐	☐	☐	☐	☐	☐	☐		
Cancer: other	☐	☐	☐	☐	☐	☐	☐	☐		
Colon polyp	☐	☐	☐	☐	☐	☐	☐	☐		
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐		
Hip fracture	☐	☐	☐	☐	☐	☐	☐	☐		
Depression	☐	☐	☐	☐	☐	☐	☐	☐		
Alcohol or drug use problem	☐	☐	☐	☐	☐	☐	☐	☐		
Alzheimer's / dementia	☐	☐	☐	☐	☐	☐	☐	☐		
Asthma	☐	☐	☐	☐	☐	☐	☐	☐		
Emphysema / COPD	☐	☐	☐	☐	☐	☐	☐	☐		
Autoimmune disease	☐	☐	☐	☐	☐	☐	☐	☐		
Bleeding or clotting disorder	☐	☐	☐	☐	☐	☐	☐	☐		
Genetic disorder	☐	☐	☐	☐	☐	☐	☐	☐		
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐		
Macular degeneration	☐	☐	☐	☐	☐	☐	☐	☐		
Hepatitis B or C	☐	☐	☐	☐	☐	☐	☐	☐		
Thyroid disease	☐	☐	☐	☐	☐	☐	☐	☐		
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐		
Kidney stones	☐	☐	☐	☐	☐	☐	☐	☐		
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐		

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HEALTH HABITS

Tobacco and vaping

Have you ever smoked cigarettes, cigars or a pipe? ☐ Never ☐ Yes

Do you vape or use e-cigarettes? ☐ Never ☐ Former ☐ Current

Other tobacco (snuff, chew)? ☐ Never ☐ Former ☐ Current

Exposure to secondhand smoke? ☐ No ☐ Yes

Current smoker: packs per day _____ for how many years _____

Former smoker: year quit _____ packs per day _____ years smoked _____

Are you ready to quit? ☐ No ☐ Yes ☐ Not applicable

Alcohol

Do you drink alcohol? ☐ No ☐ Yes Drinks per week: _____

How many times in the past year have you had 4 or more drinks (women) or 5 or more drinks (men) in one day? _____

Drug use

Have you ever used recreational drugs? ☐ No ☐ Yes

Which ones? _____

Any used currently? _____

Sexual health

Are you sexually active? ☐ Never ☐ Not currently ☐ Yes

Partner(s): ☐ Male ☐ Female ☐ Both

Birth control or STI prevention (check all that apply):
☐ None needed ☐ Condom ☐ Pill ☐ IUD ☐ Implant ☐ Patch ☐ Ring ☐ Shot ☐ Vasectomy ☐ Tubal ligation ☐ Other: _____

Diet and exercise

Do you follow a special diet? ☐ No ☐ Vegetarian ☐ Vegan ☐ Gluten-free ☐ Other: _____

Do you exercise regularly? ☐ No ☐ Yes What kind? _____

Minutes per session _____ Times per week _____

Mood

Over the past 2 weeks, have you often felt down, depressed or hopeless? ☐ No ☐ Yes

Over the past 2 weeks, have you had little interest or pleasure in doing things? ☐ No ☐ Yes

Safety

Do you wear a seatbelt consistently? ☐ Yes ☐ No

Helmet for biking or similar activities? ☐ Yes ☐ No ☐ Not applicable

Working smoke detector at home? ☐ Yes ☐ No

Guns in the home? ☐ No ☐ Yes If yes, locked with ammunition stored separately? ☐ Yes ☐ No

Has anyone hurt, threatened or frightened you, or are you afraid of someone at home? ☐ No ☐ Yes

Other

Military service? ☐ No ☐ Yes

Exposure to toxic chemicals at work or in hobbies? ☐ No ☐ Yes

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ABOUT YOU

Name you prefer we use _____ Country of birth _____

Who lives with you? ☐ No one ☐ Spouse or partner ☐ Children ☐ Parents ☐ Roommates ☐ Other: _____

Occupation (or prior occupation) _____ Employer _____

If not currently working: ☐ Retired ☐ Unemployed ☐ On leave ☐ Disabled ☐ Homemaker ☐ Student ☐ Other

Marital status: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed

Number of children _____ Ages of minor children _____ Grandchildren _____

Education: ☐ High school or GED ☐ Trade school ☐ College ☐ Graduate school ☐ Other

Interests, hobbies, or travel outside the country in the past 6 months _____

_____

ADVANCE CARE PLANNING

Check any of these Texas documents you have completed:

☐ Directive to Physicians (living will)
☐ Medical Power of Attorney
☐ Out-of-Hospital Do-Not-Resuscitate (DNR) order
☐ I know about these but have not completed them
☐ I would like information about these

WOMEN'S HEALTH

Total pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Age when periods started _____ Age when periods ended (menopause or hysterectomy) _____

☐ Not applicable

If you have periods: every _____ days, lasting _____ days. Any concerns about periods or menopause? ☐ No ☐ Yes

Thank you for taking the time to complete this form!