ATHENA FAMILY MEDICINE

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Kevin Vo, MD
Board Certified
Family Medicine

Child's name: _____ Date of birth: _____ Today's date: _____

PEDIATRIC HISTORY

ALLERGIES

Include the reaction and age it started, and note if allergies were confirmed by blood or skin testing.

Medication allergies (and reaction) _____

Food allergies _____

Does your child carry an EpiPen? ☐ No ☐ Yes

Seasonal allergies _____

CURRENT CONCERNS

_____

_____

BIRTH HISTORY

Mother's age at birth _____ Birth weight _____ Weeks of pregnancy at birth _____

Delivery: ☐ Vaginal ☐ C-section If C-section, why? _____

Complications during pregnancy (diabetes, infection, high blood pressure, breech, etc.) _____

Alcohol, drugs, smoking or medications during pregnancy _____

Problems in the newborn nursery or NICU stay? _____

Did baby go home with mom? ☐ Yes ☐ No Feeding: ☐ Breast ☐ Bottle ☐ Both Newborn hearing screen: ☐ Pass ☐ Fail ☐ Unknown

MEDICAL HISTORY

Has your child had any of the following?

Condition	Yes
ADD / ADHD	☐
Allergic rhinitis	☐
Anemia	☐
Asthma	☐
Autism spectrum disorder	☐
Chronic abdominal pain	☐
Concussion	☐
Congenital heart disease	☐
Constipation	☐
Developmental delay	☐
Diabetes	☐
Eczema	☐
Failure to thrive / poor growth	☐

Condition	Yes
Headaches	☐
Learning problems	☐
Mental health condition	☐
Heart murmur	☐
Recurrent ear infections	☐
Recurrent strep throat	☐
Reflux (GERD)	☐
Seizures	☐
Urinary tract infection	☐
Vesicoureteral reflux	☐
Vision problems	☐
Wheezing / RSV / bronchiolitis	☐

Specialists your child sees, and why _____

Other medical history _____

Child's name: _____

SURGERIES AND HOSPITAL STAYS

Surgery	Yes	Date	Surgeon or hospital
Adenoid removal	☐		
Appendix removal	☐		
Ear tubes	☐		
Heart surgery	☐		
Hernia repair	☐		
Orthopedic (bone) surgery	☐		
Tonsil removal	☐		
Urologic surgery	☐		
Other: _____	☐		

Hospital stays not listed above (and approximate dates) _____

Any reactions to vaccines? _____

Are immunizations up to date? ☐ Yes ☐ No ☐ Not sure Please bring a copy of the shot record.

Current prescription and over-the-counter medications, with doses _____

FAMILY HISTORY

Have any of the child's relatives (parents, siblings, grandparents, aunts, uncles) had these conditions?

Condition	No	Yes	Which family member?
Allergies	☐	☐	
Anemia or blood disease	☐	☐	
Arthritis	☐	☐	
Asthma or emphysema	☐	☐	
Autoimmune disease	☐	☐	
Birth defects	☐	☐	
Bone or muscle disease	☐	☐	
Cancer (type: _____)	☐	☐	
Cystic fibrosis	☐	☐	
Diabetes: ☐ Type 1 ☐ Type 2	☐	☐	
Drug or alcohol problem	☐	☐	
Eye or ear disorders	☐	☐	
Heart attack before age 50	☐	☐	
Heart disease	☐	☐	
High blood pressure	☐	☐	
Frequent or severe infections	☐	☐	
Kidney or liver disease	☐	☐	
Learning problems	☐	☐	
Mental health condition	☐	☐	
Intellectual disability	☐	☐	
Metabolic or genetic disease	☐	☐	
Nerve disorder (epilepsy, cerebral palsy)	☐	☐	
Rheumatic fever	☐	☐	
Sickle cell trait or disease	☐	☐	
Skin disease (eczema, psoriasis)	☐	☐	
Thyroid disease	☐	☐	
Tuberculosis or TB exposure	☐	☐	