Patient Information Sheet/Patient Privacy & Rights Patient Reviewed: _____

Port Lavaca Clinic Associates Employee Updated: _____

Patient Demographics	Person Responsible for Bill
Patient Full Name: _____	Responsible Party's Full Name: _____
☐ Female ☐ Male Date of Birth _____	Address: _____
Driver's License#: _____	Phone Number: _____
SS#:	Social Security: _____
Address:	Date of Birth: _____
Phone#:	Relationship to Patient: _____
Race: _____ Ethnicity: _____	
Preferred Language: _____	
Email address: _____	

**** Please list spouse and minor children under the age of 21 who you are responsible for ****

1.	2.	3.
4.	5.	6.

* Emergency Contact *

Name _____ Phone#' _____ Relationship _____

Insurance Information

Primary Ins	** Second Ins.
Policy Holder:	Policy Holder:
Relation to Policy Holder:	Relation to Policy Holder:
Policy Holder DOB:	Policy Holder DOB:
Policy#	Policy#
Group#	Group#
Female/Male SS# of insured: _____	Female/Male SS# of Insured _____
EMPLOYER: _____	EMPLOYER: _____

*** THIRD INS:

POLICY HOLDER:

RELATION TO POLICY HOLDER:

Policy Holder Date of Birth:

Policy# Group #

SS # of Insured: **Female/Male**

PATIENT BILLING AND PRIVACY

BY SIGNING BELOW YOU ARE CERTIFYING THAT THE ABOVE INFORMATION IS ACCURATE, that you are consenting for medical care & giving Port Lavaca Clinic Associates, PA. Permission to bill your insurance carrier for all medical care provided here. Your signature on this paper will be the signature on file giving us permission to file your insurance claim with "Signature on File" for Medicare; Medicaid, and all other types of insurance. **YOU ARE ALSO AGREEING THAT PAYMENT OF YOUR MEDICAL CARE IS ULTIMATELY YOUR RESPONSIBILITY.** You are also authorizing the release of any medical or other information necessary to process your medical claims as well as to other referring providers. You have access to all of your personal medical records during normal business hours. Records will be provided no more than 15 business days from receipt of request. A fee for this may be required. If you find errors in your medical records you have the rights to request changes to correct any errors. You have the right to request disclosure of non-routine disclosures of your health information. Your signature also shows that you have received our two pages Notice of privacy practice form.

_____ _____

Patient Signature (Responsible Adult if Patient is under 18 yrs. old) Date

Hoja de Información del Paciente / Privacidad y Derechos del Paciente
Port Lavaca Clinic Associates

Revisado por el paciente: _____
Actualizado por el empleado: _____

Datos Demográficos del Paciente	Persona Responsable de la Factura
Nombre completo del paciente: _____ ☐ Femenino ☐ Masculino Fecha de nacimiento _____ Licencia de conducir #: _____ SS #: _____ Dirección: _____ Teléfono #: _____ Raza: _____ Etnicidad: _____ Idioma preferido: _____ Correo electrónico: _____	Nombre completo de la persona responsable: _____ Dirección: _____ Número de teléfono: _____ Seguro Social: _____ Fecha de nacimiento: _____ Relación con el paciente: _____

**** Indique el cónyuge y los hijos menores de 21 años de los cuales usted es responsable ****

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

* Contacto de Emergencia *
Nombre _____ Teléfono # _____ Relación _____

Información del Seguro

Seguro Primario	** Segundo Seguro
Titular de la póliza: _____ Relación con el titular: _____ Fecha de nacimiento del titular: _____ Póliza #: _____ Grupo #: _____ Femenino/Masculino SS # del asegurado: _____ EMPLEADOR: _____	Titular de la póliza: _____ Relación con el titular: _____ Fecha de nacimiento del titular: _____ Póliza #: _____ Grupo #: _____ Femenino/Masculino SS # del asegurado: _____ EMPLEADOR: _____

*** TERCER SEGURO:
TITULAR DE LA PÓLIZA: _____
RELACIÓN CON EL TITULAR: _____
Fecha de nacimiento del titular: _____
Póliza #: _____ Grupo #: _____
SS # del asegurado: _____ Femenino/Masculino

FACTURACIÓN Y PRIVACIDAD DEL PACIENTE

AL FIRMAR A CONTINUACIÓN, USTED CERTIFICA QUE LA INFORMACIÓN ANTERIOR ES CORRECTA, que está dando su consentimiento para recibir atención médica y autoriza a Port Lavaca Clinic Associates, PA. a facturar a su compañía de seguros por toda la atención médica proporcionada aquí. Su firma en este documento será la firma registrada que nos autoriza a presentar su reclamación de seguro con una "Firma en Archivo" para Medicare, Medicaid y cualquier otro tipo de seguro. USTED TAMBIÉN ACEPTA QUE EL PAGO DE SU ATENCIÓN MÉDICA ES, EN ÚLTIMA INSTANCIA, SU RESPONSABILIDAD. También autoriza la divulgación de cualquier información médica u otra información necesaria para procesar sus reclamaciones médicas, así como a otros proveedores que lo refieran. Usted tiene acceso a todos sus expedientes médicos personales durante el horario normal de oficina. Los expedientes se proporcionarán a más tardar 15 días hábiles después de recibir la solicitud. Es posible que se cobre una tarifa. Si encuentra errores en sus expedientes médicos, tiene derecho a solicitar cambios para corregirlos. Tiene derecho a solicitar información sobre divulgaciones no rutinarias de su información de salud. Su firma también confirma que ha recibido nuestro Aviso de Prácticas de Privacidad de dos páginas.

_____

Firma del paciente (Adulto responsable si el paciente es menor de 18 años) Fecha

NOTICE OF PRIVACY PRACTICES

Port Lavaca Clinic Associates
Effective Date: [Insert Date]

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR RESPONSIBILITIES

Port Lavaca Clinic Associates is required by law to:

- Maintain the privacy of your protected health information ("PHI")
- Provide you with this Notice of our legal duties and privacy practices
- Follow the terms of the Notice currently in effect
- Notify you if a breach occurs that may have compromised the privacy or security of your information

---

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

1. Treatment

We may use and disclose your PHI to provide, coordinate, or manage your healthcare.
Example: Sharing information with a specialist, lab, or hospital.

---

2. Payment

We may use and disclose your PHI to bill and receive payment.
Example: Sending information to your insurance company for claims processing.

---

3. Healthcare Operations

We may use your PHI for clinic operations.
Examples include:

- Quality improvement
- Staff training
- Licensing and accreditation

---

4. Appointment Reminders and Health-Related Benefits

We may contact you for:

- Appointment reminders
- Follow-up care
- Treatment options or health-related services

---

5. Individuals Involved in Your Care

We may share information with family members, friends, or others involved in your care unless you object.

---

6. Required by Law

We will disclose your PHI when required by federal, state, or local law.

---

7. Public Health Activities

We may disclose your information for:

- Disease control and prevention
- Reporting births, deaths, or infections
- Reporting abuse or neglect

---

8. Health Oversight Activities

We may disclose PHI to health oversight agencies for audits, inspections, and investigations.

---

9. Law Enforcement

We may release PHI:

- In response to a court order or subpoena
- To report certain crimes

---

10. Serious Threat to Health or Safety

We may disclose information to prevent or lessen a serious threat.

---

11. Workers' Compensation

We may disclose PHI as authorized for workers' compensation claims.

---

12. Research

We may use or disclose PHI for research under strict approval processes.

USES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

We will not use or disclose your PHI without your written authorization for:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

You may revoke authorization at any time in writing.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Right to Access

You may inspect and obtain a copy of your medical records.

---

2. Right to Amend

You may request corrections to your health information.

---

3. Right to an Accounting of Disclosures

You may request a list of certain disclosures we have made.

---

4. Right to Request Restrictions

You may request limits on how we use or disclose your PHI.
We are not required to agree, except in certain cases involving self-pay.

---

5. Right to Request Confidential Communications

You may request we contact you in a specific way (e.g., only by phone or mail).

---

6. Right to a Paper Copy

You may request a paper copy of this Notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. Updated versions will be available in our clinic and upon request.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with:

Port Lavaca Clinic Associates
Phone: [Insert Phone Number]

Or with the U.S. Department of Health and Human Services:
Office for Civil Rights
You will not be penalized for filing a complaint.

CONTACT INFORMATION

If you have questions about this Notice, contact:

Port Lavaca Clinic Associates
[Insert Address]
Phone: [Insert Phone Number]

Port Lavaca Clinic

1200 N Virginia St, Port Lavaca, TX 77979
Phone: (361) 552-6721

Telemedicine Visit Rules & Expectations

Appropriate Clothing

Patients must wear proper, non-revealing clothing during the entire visit.

Private Environment

The visit must take place in a quiet, private location where your personal health information cannot be overheard. Avoid public areas, shared spaces, or environments with distractions. Ensure good lighting so the provider can see you clearly.

Safety Requirements

Do not attend a telemedicine visit while driving or operating any type of vehicle or machinery. All vehicles or machinery must be completely stopped and safely parked before the appointment begins.

Technology Setup

Use a device with a functioning camera and microphone. Ensure your internet connection is stable before the appointment. Keep your device plugged in or fully charged.

Respect & Professionalism

Treat the visit as you would an in-person appointment. Avoid multitasking during the session. Follow your provider's instructions and be prepared with any requested documents, medication lists, or readings.

Rule Enforcement

Failure to follow these rules will result in the telemedicine session being terminated. The appointment must then be rescheduled.

Thank you for your cooperation.

HEALTH HISTORY

PORT LAVACA CLINIC ASSOCIATES, P.A.
1200 N. VIRGINIA ST. PORT LAVACA, TEXAS 77979 361-552-6721

DATE:_____

Name:_____ Age:_____ Birth Date:___/___/___
Last First MI Sex: Male Female

Highest Grade Completed _____
Place of Employment _____ How Long? _____ Occupation _____
Single Married Separated Divorced Widowed

Others Who Live With You	Relationship	Age	Receive Care Here?
			yes no
			yes no
			yes no
			yes no
			yes no

Do you have any special spiritual, religious, or cultural needs? No Yes Explain_____

ALLERGIES: Any allergies or reactions to any medications, X-ray dyes, foods, environmental or other substances? No Yes (please list)
1._____ 2._____ 3._____ 4._____

PAST MEDICAL HISTORY AND REVIEW OF SYSTEMS:
Please circle if you have had problems with or are presently complaining of any of the following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest Pain/discomfort
6. Shortness of Breath
7. Swollen Ankles
8. Palpitations
9. Lightheadedness
10. Stroke
11. High cholesterol
12. Fever, chills, sweats
13. Pneumonia
14. Persistent Cough
15. Tuberculosis (TB)
16. Asthma
17. Hayfever
18. Indigestion/ heartburn
19. Abdominal Discomfort
20. Change in appetite
21. Constipation or diarrhea
22. Unexplained Wt Gain/Loss
23. Blood in Stool
24. Ulcers
25. Hemorrhoids
26. Gallbladder Disease
27. Hepatitis or liver disease
28. Thyroid Disease
29. Seizures
30. Headaches
31. Incontinence
32. Kidney Diseases
33. Kidney Stones
34. Difficulty Urinating
35. Urine Infections
36. Arthritis
37. Blood disorder
38. Sickle cell
39. Blood clots
40. Anemia
41. Anxiety
42. Depression
43. Skin Diseases
44. Hearing difficulty
45. Gout
46. Low Back Problems
47. Glasses or contacts
48. Glaucoma/cataracts

Any problems not listed above: _____

Are you on a special diet? No Yes Type: _____
Do you use any community resources? (i.e. Home Health, etc.) No Yes Which? _____

FEMALE HEALTH HISTORY:
Age of start of periods: _____ years old
Frequency: _____ Length of Period: _____ days
Pregnancies: _____
Births: _____ Miscarriages: _____
Method of Birth Control: _____

Prolonged of Abnormal Bleeding	No Yes
Leakage of Urine	No Yes
Pelvic Pain	No Yes
Abnormal Discharge	No Yes
History of Abnormal Pap Smear	No Yes
Sexually transmitted disease	No Yes

MALE HEALTH HISTORY:

Testicular masses	No Yes
Discharge from the penis	No Yes
Sexually transmitted disease	No Yes
Problems with erections	No Yes
Difficulty urinating	No Yes

Please turn OVER

OPERATIONS: No Yes (please list)

Type of Operation	When

OTHER HOSPITALIZATIONS: No Yes (please list)

Reason	When

Vaccination History-Have you had?
Hepatitis B? No Yes When? _____
Other? No Yes When? _____
When was your last?
Pap Smear _____
Mammogram _____
Bone Density _____

Breast Exam _____
Cholesterol _____

Tetanus Immunization No Yes When? _____
Flu Immunization No Yes When? _____
Pneumonia Immunization No Yes When? _____

Colon Cancer Screen _____
Prostrate Exam _____

FAMILY HISTORY: Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which Family Member?	Approximate age when diagnosed
Cancer (describe type)		
High Blood Pressure		
Heart Disease		
Diabetes		
Stroke		
Mental Illness (anxiety, depression, etc.)		
Blood/clotting Disease		
Other:		

MEDICATIONS: (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose

Drug Name	Dose

PREVENTION:

Do you wear seatbelts? No Yes If no, why not? _____
Do you wear a bicycle or motorcycle helmet? No Yes Not applicable
Do you smoke or use tobacco products? No Yes If yes, how may packs/day? _____
Do you drink alcoholic beverages? No Yes If yes, how many/week? _____
Is there a gun in your home? No Yes
Do you use drugs? (marijuana, cocaine, crack, etc.) No Yes If yes, list _____
Any behaviors which would increase your risk of AIDS? (IV drug use, unprotected intercourse, same sex relationship) No Yes
Do you wish to be tested for AIDS? No Yes
Have you ever worked with chemicals, paints, asbestos, or other household materials? No Yes If yes, explain _____
Have you ever been or are you in a relationship in which your partner hurt you? (e.g. slapped, kicked, punched, bruised) No Yes
Have you ever felt afraid of your partner? No Yes
Do you have a "living will"? No Yes
Are you an organ donor? No Yes

HISTORIAL MÉDICO

PORT LAVACA CLINIC ASSOCIATES, P.A.
1200 N. VIRGINIA ST. · PORT LAVACA, TEXAS 77979 · 361-552-6721

FECHA: _____

Nombre: _____ Edad: ____ Fecha de nacimiento: ___/___/___
Apellido Nombre Inicial Sexo: Masculino / Femenino

Último grado completado: _____ Lugar de empleo: _____ ¿Cuánto tiempo? _____ Ocupación: _____

Estado civil: Soltero(a) ____ Casado(a) ____ Separado(a) ____ Divorciado(a) ____ Viudo(a) ____

Otras personas que viven con usted	Relación	Edad	¿Recibe atención aquí?
			Sí No
			Sí No
			Sí No
			Sí No
			Sí No

¿Tiene alguna necesidad espiritual, religiosa o cultural especial? No Sí Explique: _____

ALERGIAS: ¿Tiene alergias o reacciones a medicamentos, medios de contraste para rayos X, alimentos, sustancias ambientales u otras? No Sí
(enumere) 1. _____ 2. _____ 3. _____ 4. _____

ANTECEDENTES MÉDICOS Y REVISIÓN DE SISTEMAS:

Marque si ha tenido problemas o actualmente presenta alguno de los siguientes:

1. Presión arterial alta
2. Diabetes
3. Cáncer
4. Enfermedad cardíaca
5. Dolor/molestia en el pecho
6. Falta de aire
7. Tobillos hinchados
8. Palpitaciones
9. Mareos
10. Derrame cerebral
11. Colesterol alto
12. Fiebre/escalofríos/sudores
13. Neumonía
14. Tos persistente
15. Tuberculosis (TB)
16. Asma
17. Fiebre del heno/alergias
18. Indigestión/acidez
19. Molestia abdominal
20. Cambio de apetito
21. Estreñimiento/diarrea
22. Aumento/pérdida de peso
23. Sangre en las heces
24. Úlceras
25. Hemorroides
26. Enfermedad de vesícula
27. Hepatitis/enfermedad hepática
28. Enfermedad tiroidea
29. Convulsiones
30. Dolores de cabeza
31. Incontinencia
32. Enfermedad renal
33. Piedras en el riñón
34. Dificultad para orinar
35. Infecciones urinarias
36. Artritis
37. Trastorno sanguíneo
38. Anemia falciforme
39. Coágulos sanguíneos
40. Anemia
41. Ansiedad
42. Depresión
43. Enfermedades de la piel
44. Dificultad auditiva
45. Gota
46. Problemas de espalda baja
47. Lentes/contactos
48. Glaucoma/cataratas

¿Algún problema no mencionado arriba? _____

¿Sigue una dieta especial? No Sí Tipo: _____

¿Utiliza recursos comunitarios? (ej. atención en el hogar) No Sí ¿Cuál? _____

HISTORIAL DE SALUD FEMENINA:

Edad al inicio de menstruación: ___ años
Frecuencia: ____ Duración: ___ días
Embarazos: ____ Partos: ____ Abortos espontáneos: ___
Método anticonceptivo: _____
Sangrado anormal prolongado No Sí
Pérdida de orina No Sí
Dolor pélvico No Sí
Flujo vaginal anormal No Sí
Papanicolaou anormal No Sí
Enfermedad de transmisión sexual No Sí

HISTORIAL DE SALUD MASCULINA:

Masas testiculares No Sí
Secreción del pene No Sí
Enfermedad de transmisión sexual No Sí
Problemas de erección No Sí
Dificultad para orinar No Sí

Por favor, VOLTEE LA PÁGINA

OPERACIONES: No Sí (enumere)

Tipo de operación	Cuándo

OTRAS HOSPITALIZACIONES: No Sí (enumere)

Motivo	Cuándo

Historial de vacunación - ¿Ha recibido?

Hepatitis B? No Sí ¿Cuándo? _____ Tétanos No Sí ¿Cuándo? _____

Otra? No Sí ¿Cuándo? _____ Influenza No Sí ¿Cuándo? _____

Neumonía No Sí ¿Cuándo? _____

Último Papanicolaou _____ Examen de mama _____ Detección de cáncer de colon _____

Mamografía _____ Colesterol _____ Examen de próstata _____ Densidad ósea _____

HISTORIAL FAMILIAR: ¿Algún miembro de su familia (incluyendo padres, abuelos y hermanos) ha tenido alguno de los siguientes?

Enfermedad	¿Qué miembro de la familia?	Edad aproximada al diagnóstico
Cáncer (describa tipo)		
Presión arterial alta		
Enfermedad cardíaca		
Diabetes		
Derrame cerebral		
Enfermedad mental (ansiedad, depresión, etc.)		
Enfermedad de sangre/coagulación		
Otro		

MEDICAMENTOS: (Recetados, de venta libre, vitaminas, hierbas, etc.)

Nombre del medicamento	Dosis

Nombre del medicamento	Dosis

PREVENCIÓN:

¿Usa cinturón de seguridad? No Sí Si no, ¿por qué? _____

¿Usa casco al andar en bicicleta o motocicleta? No Sí No aplica

¿Fuma o usa productos de tabaco? No Sí Si sí, ¿cuántos paquetes/día? _____

¿Consume bebidas alcohólicas? No Sí Si sí, ¿cuántas/semana? _____

¿Hay un arma de fuego en su hogar? No Sí

¿Usa drogas? (marihuana, cocaína, crack, etc.) No Sí Si sí, enumere _____

¿Tiene conductas que aumentarían su riesgo de SIDA? (drogas IV, sexo sin protección, relación con persona del mismo sexo) No Sí

¿Desea hacerse una prueba de SIDA? No Sí

¿Ha trabajado con químicos, pinturas, asbesto u otros materiales domésticos? No Sí Explique _____

¿Ha estado o está en una relación en la que su pareja le haya lastimado (abofeteado, pateado, golpeado, causado moretones)? No Sí

¿Alguna vez ha sentido miedo de su pareja? No Sí

¿Tiene un "testamento vital"? No Sí

¿Es donante de órganos? No Sí

Port Lavaca Clinic

Consent to Treatment of a Minor

Name of Minor: _____

Minor's Treatment: I am the parent/guardian, _____
Printed Name of Parent/Guardian

For the above named minor patient I authorize Port Lavaca Clinic's medical staff to provide medical/dental/vision, and/or emergency treatment to my child. I understand that this authorization is given in advance of any specific diagnosis or treatment. I, the parent/guardian am financially responsible to pay the cost of the services rendered to the child in accordance with the regular rate and terms of Port Lavaca Clinic. Family members (grandparents, aunt/uncles, cousins, adult siblings) and the following designated unrelated adults:

_____

_____

May bring the minor in for treatment at the Port Lavaca Clinic.

I understand that this form will be valid and remain in effect for one year from the date signed below. This form has been fully explained to me and I understand its contents.

_____ _____ _____

Signature Parent/Guardian | Relationship to Minor | Date

Authorization to Release Patient Information

Patient's Name: _____

Date of Birth: _____

Social Security #: _____

This is to authorize the following person(s):

⇨ _____

⇨ _____

⇨ _____

Access to my personal information as shown below:

_____ Billing record

_____ To discuss my medical condition with my provider

This authorization will remain in effect until written notification from my self is received by the Port Lavaca Clinic.

_____ _____

Signature Date

Autorización para Divulgar Información del Paciente

Nombre del paciente: _____

Fecha de nacimiento: _____

Número de Seguro Social: _____

Por medio de la presente autorizo a la(s) siguiente(s) persona(s):

- → _____
- → _____
- → _____

A tener acceso a mi información personal según se indica a continuación:

_____ Registro de facturación

_____ Hablar sobre mi condición médica con mi proveedor

Esta autorización permanecerá vigente hasta que Port Lavaca Clinic reciba de mi parte una notificación por escrito.

_____

Firma Fecha

PEDIATRIC HEALTH HISTORY

PORT LAVACA CLINIC ASSOCIATES, P.A.
1200 N. VIRGINIA ST. PORT LAVACA, TEXAS 77979 361-552-6721

DATE:_____

Name: _____ Age: _____ Birth Date: ___/___/____
Last First MI Sex: Male Female

PREGNANCY & BIRTH
Is the child yours by: birth adoption stepchild other: _____
Any medical problems during pregnancy none yes _____
Delivery by vaginal birth caesarian If caesarian, why? _____
Length of pregnancy: _____
Birth weight: _____ Birth length: _____
Any medical problems during the baby's first few days none yes _____
Was the first hepatitis vaccine given in the hospital? no yes

NUTRITION & FEEDING
Was your child breastfed? no yes If so, how long?
Has your child had any unusual feeding/dietary problems? no yes If so, how long? _____
Milk intake now cow milk (non-fat 1% fat 2% fat whole milk) soy milk rice milk
Average ounces per day (Note: 8 ounces are in 1 cup)_____

SLEEP
Hours per night _____ Naps (number and length) _____
Sleep problems no yes _____

DEVELOPMENT
At what age did your child: sit alone _____ walk alone _____ say words _____ toilet train _____
Girls only: Age at first menstrual period _____

DENTAL HISTORY
Has your child been seen by a dentist? no yes If so, how often _____ Date of last visit _____

IMMUNIZATIONS/INFECTIOUS DISEASES: Please bring the child's shots records to your appointment.
Has your child had: chicken pox measles mumps rubella meningitis tuberculosis (TB)

EXPOSURES/HABITS
Any concerns about lead exposure? (old home, plumbing/peeling paint) no yes
Do any household members smoke? no yes
TV hours per day _____ Computer hours per day _____ Video game hours per day _____
How many soft drinks a day? _____

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates

_____
_____
_____
_____

MEDICATIONS:

_____
_____
_____
_____

ALLERGIES: Any allergies or reactions to any medications, X-ray dyes, foods, environmental or other substances? No Yes (please list)
1._____ 2._____ 3._____ 4._____

Please turn OVER

HOSPITALIZATIONS/OPERATIONS (with dates):

_____
_____
_____
_____

FAMILY HISTORY: please circle any family history of the following (indicate who has/had the condition):

Alcoholism/drug abuse	Heart disease or stroke before age 60	Seizures
Depression/psychiatric disorder	Thyroid disease	Kidney disease
High blood pressure	Bleeding/clotting problems	Birth defects
Asthma/hayfever/eczema	Inherited/genetic disorder	

SCHOOL HISTORY:

Did/does your child attend preschool? no yes Current grade?_____ Name of school _____
Any concerns about school performance no yes _____
Any concerns about relationships with: Teachers no yes _____
Students no yes _____
Sports/Exercise: Type _____ How often? _____

SOCIAL HISTORY:

Fathers name:_____ Age:
Mothers name: _____ Age:
Parents occupations: Mother _____ Father _____
Are the child's parents Married Unmarried Separated Divorced If divorced, when_____
Child care situation parents others (specify who and hours per day) _____
Any pets? no yes If yes, what kind? _____

Others Who Live At Home	Relationship	Age	Receive Care Here?
			yes no
			yes no
			yes no
			yes no
			yes no

Concerns about your child: alcohol use smoking drugs sex aggressive behavior withdrawn
Is violence in the home a concern? no yes Are there guns in the home? no yes

REVIEW OF SYSTEMS: (Please circle)

1. Fevers/chills/excessive sweating
2. Unexpected weight loss/gain
3. Squinting/ crossed eyes/ lazy eye
4. Loud voice/ hard of hearing
5. Mouth breathing/ snoring
6. Bad breath
7. Frequent runny nose
8. Problems with teeth/gums
9. Nausea/ vomiting/ diarrhea
10. Constipation
11. Blood in bowel movement
12. Tires easily with exercise
13. Shortness of breath
14. Fainting
15. Asthma
16. Bedwetting
17. Pain with urination
18. Discharge: penis or vagina
19. Headaches
20. Weakness
21. Clumsiness
22. Muscle/ joint pain
23. Hayfever/ itchy eyes
24. Rashes
25. Unusual moles
26. Speech problems
27. Anxiety/Stress
28. Sleeping problems
29. Depression
30. Thumbsucking/ nail biting
31. Bad temper/ breath holding
32. Unexplained lumps
33. Easy bruising/ bleeding
34. Broken bones

HISTORIA DE SALUD PEDIÁTRICA

PORT LAVACA CLINIC ASSOCIATES, P.A.
1200 N. VIRGINIA ST. PORT LAVACA, TEXAS 77979 361-552-6721

FECHA:_____

NOMBRE: _____ EDAD:_____ FECHA DE NACIMIENTO: _____

GÉNERO: Hombre/Mujer

EMBARAZO Y NACIMIENTO

¿Es su niño por: nacimiento adopción hijastro otra: _____
Cualquier problema médico durante el embarazo? Ninguno Sí _____
Entrega vaginal o parto cesárea. Si cesárea, ¿por qué? _____
Duracion de embarazo: _____
El peso al nacer: _____ Tamano al nacimiento: _____
Cualquier problema médico durante el primer par de días del bebé? No Sí
Fue la primera vacuna contra la Hepatitis administrada en el hospital? No Sí

NUTRICIÓN Y ALIMENTACIÓN

Fue amamantado a su hijo? no o sí. Si es así, ¿cuánto tiempo?
¿Su hijo ha tenido algun problema de alimentación / problemas dietéticos inusuales? No o Sí.
Si es así, ¿cuánto tiempo? _____
El consumo de leche ahora? Leche de vaca (sin grasa / 1% de grasa / 2% de grasa / de leche entera) / de leche de soja / leche de arroz? (Marque uno.)
Promedio onzas por día? (Nota: 8 oz están en 1 taza) _____

DORMIR

Horas por día: _____ Siestas: (número y duración) _____
Tiene problemas de sueño? No o Sí

DESARROLLO

¿A qué edad su hijo: se sienta solo _____ camino solo _____ dicir palabras _____ se enseno a hacer el bano _____
Niñas solo: Edad de la primera menstruación _____

HISTORIA DENTAL

¿Su hijo ha sido visto por un dentista? No o Sí.
Fecha de la última visita _____

INMUNIZACIONES / ENFERMEDADES INFECCIOSAS

¿Su hijo ha tenido: Sarampión / Parotiditis / Varicela / Rubéola / Meningitis / Tuberculosis