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