



Thank you for choosing us!

## PEDIATRIC/ADOLESCENT PATIENT QUESTIONNAIRE (age <19)

In order to best care for you, please fill out the following information. This form only needs to be completed once so we can enter the information in our new electronic health record. If you have already completed this form since we started using it on in July 2009, you do not need to fill it out again. If you are unsure of a question or do not feel well enough to complete this form you may leave it blank and ask for assistance from the medical assistant when you are called back.

Thank you.

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Name of Physician/Provider you are seeing today: \_\_\_\_\_

Our practice can send prescriptions electronically to local pharmacies that are connected to the Pharmacy Health Information Exchange™, operated by SureScripts®. Instead of a paper prescription, we can send the same information directly to the pharmacy's computer.

Preferred Pharmacy (Name & Location) \_\_\_\_\_

Alternate Pharmacy (Name & Location) \_\_\_\_\_

**(NOTE: Naval hospital currently DOES NOT accept electronic prescriptions)**

Do you have a copy of your child's immunization record?  No,  Yes, Please provide with this document.

### Medications

Is the patient currently taking any medications?  No  Yes, please list medication and dosage if known:

\_\_\_\_\_  
\_\_\_\_\_

### Allergies

Is the patient allergic to anything?  No  Yes, please list drug(s) and reaction(s): \_\_\_\_\_

\_\_\_\_\_

### Immunizations (approximate dates are fine)

Date of patient's last flu shot? \_\_\_\_\_  None

Date of patient's last pneumonia shot? \_\_\_\_\_  None

Date of patient's last tetanus shot? \_\_\_\_\_  None

**Chronic Illness:**

Do you have any current chronic illnesses such as: Diabetes, Hypertension, Heart Disease, Asthma, ADD/ADHD, etc?  No  Yes, please list: \_\_\_\_\_

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**Past Medical History**

Have you had any prior serious illness or surgeries?  No  Yes, please list including dates if known:

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Has the patient ever been hospitalized?  No  Yes, Please explain: \_\_\_\_\_

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Has the patient ever has any surgeries?  No  Yes, Please explain: \_\_\_\_\_

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**Family History (possible genetic illnesses)**

Has anyone in your immediate family had any major illnesses, such as heart disease, cancer, diabetes, etc?  No  Yes, please list which family member and illness? \_\_\_\_\_

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**Social History**

Mother's Occupation: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Parent Relationship:  Married  Divorced  Never Married  Separated  Other.

Are there any occupational hazards at your place of employment such as: asbestos, chemicals, excessive noise, potentially toxic fumes?  No  Yes, please list: \_\_\_\_\_

Are there smokers in the home?  No  Yes, please list quantity: \_\_\_\_\_

Primary Residence of Patient: \_\_\_\_\_

Child Care?  No  Yes If so how many hours per week? \_\_\_\_\_

Language spoken at home? \_\_\_\_\_

Patient's School Name: \_\_\_\_\_

Patient's grade in school: \_\_\_\_\_

Medical Record Use Only: Abstracted by \_\_\_\_\_



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**NEWBORN INTAKE FORM**

**Pregnancy/ Birth History**

Maternal age: \_\_\_\_\_ Due Date \_\_\_\_\_ Marital Status: Married/Single/Separated/Divorced/Widow

Mother Blood type: A B AB O : Rh type: + / -

Group B Strep: \_\_\_\_\_ positive; \_\_\_\_\_ negative; \_\_\_\_\_ don't know

Any Abnormal prenatal labs: \_\_\_\_\_

Maternal Illnesses/complications: \_\_\_\_\_

Maternal Infection: \_\_\_\_\_

Pregnancy medications: \_\_\_\_\_

**Delivery**

Hospital/Location of Delivery: \_\_\_\_\_

Type of Delivery: \_\_\_\_\_ Normal Vaginal, \_\_\_\_\_ Elective C-Section, \_\_\_\_\_ Emergent C-Section  
\_\_\_\_\_ Vaginal forceps, \_\_\_\_\_ Vaginal Vacuum

Gestation: \_\_\_\_\_ weeks; Birth Weight \_\_\_\_\_ lb \_\_\_\_\_ oz ; Length \_\_\_\_\_ inch

Apgar scores: \_\_\_\_\_ 1 min; \_\_\_\_\_ 5 min Amniotic fluid : clear / Meconium stained

Maternal fever \_\_\_\_\_ Yes, \_\_\_\_\_ No

**Hospital Course**

Vitamin K: \_\_\_\_\_ Yes, \_\_\_\_\_ No; Hepatitis B Vaccine: \_\_\_\_\_ Yes, \_\_\_\_\_ No

Hearing Test: \_\_\_\_\_ pass, \_\_\_\_\_ fail

Jaundice : \_\_\_\_\_ Yes, \_\_\_\_\_ No ; Treated with Phototherapy: \_\_\_\_\_ Yes, \_\_\_\_\_ No

Treated with Antibiotics: \_\_\_\_\_ Yes, \_\_\_\_\_ No

NICU: \_\_\_\_\_ Yes, \_\_\_\_\_ No; Diagnosis in NICU: \_\_\_\_\_

Days in NICU \_\_\_\_\_, Ventilator \_\_\_\_\_ Yes, \_\_\_\_\_ No

Blood Transfusion: \_\_\_\_\_ Yes, \_\_\_\_\_ No;

Abnormal Tests in hospital: \_\_\_\_\_ Yes, \_\_\_\_\_ No; if yes specify \_\_\_\_\_

**Discharge from Hospital**

Feedings: \_\_\_\_\_ Breast, \_\_\_\_\_ Bottle, \_\_\_\_\_ Both: Formula Type : \_\_\_\_\_

Date of Hospital Discharge: \_\_\_\_\_

Adoption : \_\_\_\_\_ Yes, \_\_\_\_\_ No

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