Patient Information Form

Brent K. Eberhard, M.D.

Date	Child's Name	Nickname	DOB	M F

Previous Physician/Office	Request for Records Transfer Complete Y N	Date of Last Physical

Mother's Name	Occupation	Age	Father's Name	Occupation	Age

Birth History

Birth Weight ________________ Preg # ____ Mother's age ________________________
Gestational Age ______________
Did mother have any illness or problems with her pregnancy? ☐Y ☐N
Explain ____

Did mother experience problems during labor and delivery? ☐Y ☐N
Explain ____
During Pregnancy, did mother:
Smoke ☐Y ☐N Drink Alcohol ☐Y ☐N
Use drugs or medications:
What ______________________________ When ____________________________

Was the delivery ☐Vaginal? ☐Cesarean?
If Cesarean, why? ____
Did your baby have any problems right after birth? ☐Y ☐N
Explain ____

Hospital ____
Hep B Given? Blood Type __________
Group B Strep Pos _______ Neg _______
If positive, antibiotics given? Doses? ______________
Was initial feeding? ☐Breastmilk? ☐Formula?
Did your baby go home with mother from the hospital? ☐Y ☐N
If no, explain ____

Current and Past History

Question	Y	N	Explain
Is your child currently on any medication?	☐	☐	Explain
Does your child have any serious or chronic illnesses?	☐	☐	Explain
Has your child had serious injuries or accidents?	☐	☐	Explain
Has your child had any surgery?	☐	☐	Explain
Has your child ever been hospitalized?	☐	☐	Explain
Is your child allergic to any medicine or drugs?	☐	☐	Explain
Has your child had any reactions to immunizations?	☐	☐	Explain

Does your Child Have, or Ever Had:

Condition	Y	N	Explain
Asthma, recurrent cough, bronchitis, or pneumonia	☐	☐	Explain
Nasal allergies or eczema	☐	☐	Explain
Frequent ear infections or sore throats	☐	☐	Explain
Problems with ears or hearing	☐	☐	Explain
Problems with eyes, vision, or teeth	☐	☐	Explain
Frequent headaches or other neurologic problems	☐	☐	Explain
Frequent abdominal pain	☐	☐	Explain
Constipation requiring doctor visits	☐	☐	Explain
Bladder/kidney infection or bed-wetting (after 5 y.o.)	☐	☐	Explain
Any heart problem or heart murmur	☐	☐	Explain
Anemia or bleeding problem	☐	☐	Explain
Thyroid or other endocrine problem	☐	☐	Explain
Diabetes	☐	☐	Explain
ADHD	☐	☐	Explain
Mental health issues (anxiety, depression)	☐	☐	Explain
Use of alcohol or drugs	☐	☐	Explain
Any other medical or mental health issues/problems	☐	☐	Explain

Question	Y	N	
Does your child see any specialists?	☐	☐	If yes, Who?
For what reason or diagnosis?			
Has your child ever received Occupational Therapy?	☐	☐	Explain
Physical Therapy, Speech Therapy?	☐	☐	Explain
Is your child in special or resource classes in school?	☐	☐	Explain

Do you have any other issues or concerns not listed above?

Household Information		
Please List All Those Living in the Child's Home		
Name	Relationship to Child	Date of Birth

Child Care: ____ Smoke & Carbon Monoxide Detectors? __________________________

Smokers in Household? ______________________________ Pets in Household? ____

Are there siblings not listed? If so, please list their names and ages and where they live. ____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

Family Medical History (Parents, Siblings, Grandparents, Aunts & Uncles)

Have any Family Members Had The Following:

Condition	Y	N	Who?	Comments
Alcohol/Drug Abuse	☐ Y	☐ N	Who? ____________________	Comments ____________________
Allergies	☐ Y	☐ N	Who? ____________________	Comments ____________________
Anesthesia Risk	☐ Y	☐ N	Who? ____________________	Comments ____________________
Arthritis	☐ Y	☐ N	Who? ____________________	Comments ____________________
Blood Disease	☐ Y	☐ N	Who? ____________________	Comments ____________________
Cancer	☐ Y	☐ N	Who? ____________________	Comments ____________________
Diabetes	☐ Y	☐ N	Who? ____________________	Comments ____________________
Genetic	☐ Y	☐ N	Who? ____________________	Comments ____________________
Gastroenteritis	☐ Y	☐ N	Who? ____________________	Comments ____________________
Genitourinary	☐ Y	☐ N	Who? ____________________	Comments ____________________
Heart	☐ Y	☐ N	Who? ____________________	Comments ____________________
Hypertension	☐ Y	☐ N	Who? ____________________	Comments ____________________
Lipids	☐ Y	☐ N	Who? ____________________	Comments ____________________
Neurologic Diagnosis	☐ Y	☐ N	Who? ____________________	Comments ____________________
Psychiatry	☐ Y	☐ N	Who? ____________________	Comments ____________________
Ophthalmology	☐ Y	☐ N	Who? ____________________	Comments ____________________
Respiratory	☐ Y	☐ N	Who? ____________________	Comments ____________________
Skin	☐ Y	☐ N	Who? ____________________	Comments ____________________
Stroke	☐ Y	☐ N	Who? ____________________	Comments ____________________
Thyroid	☐ Y	☐ N	Who? ____________________	Comments ____________________

Additional Family History/Comments ____