Patient Information Form

Brent K. Eberhard, M.D.

Child's Name	Nickname	DOB	M F
Previous Physician/Office		Date of Last Physical	
Mother's Name	Occupation		
Father's Name	Occupation		

Birth History

Birth Weight ____________ Gestational Age ______________________	Was the delivery Vaginal Cesarean
Hospital ____	If Cesarean, why? ____
Did mother have any problems during pregnancy?	Did your baby have any problems right after birth?
Explain ____	Explain ____
	Any Jaundice?
	Explain
Did mother experience problems during labor and delivery?	Group B Strep Positive Negative
Explain ____	If positive, antibiotics given? Doses? __________
	Hep B Given? Blood Type __________
What medications were taken during pregnancy?__________________	
	Was initial feeding Breast Milk? Formula?
	Passed Hearing Screen
Any Drugs/Alcohol/Tobacco?	

Current and Past History

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:

Asthma, recurrent cough, bronchitis, or pneumonia	Explain ____
Nasal allergies or eczema	Explain ____
Frequent ear infections or sore throats	Explain ____
Constipation requiring doctor visits	Explain ____
Bladder/kidney infections?	Explain ____
Any heart problem or heart murmur	Explain ____
Mental health issues (anxiety, depression)	Explain ____
Use of alcohol or drugs	Explain ____

Any other medical or mental health issues/problems?

Does your child see any specialists?	If yes, who? ____
For what reason or diagnosis? ______________________________	
Has your child ever received Occupational Therapy?	If yes, explain ____
Physical Therapy, Speech Therapy? ______________________________	
Is your child in specal or resource classes in school?	If yes, explain ____
Do you have any other issues or concerns not listed above? ______________________________	

~CONTINUE ON BACK~

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. ______________________________________

Family Medical History (Parents, Siblings, Grandparents)

Have any Family Members Had The Following:

Alcohol/Drug Abuse	Who? _______________	Comments _______________
Allergies	Who? _______________	Comments _______________
Asthma	Who? _______________	Comments _______________
Blood Disease	Who? _______________	Comments _______________
Cancer	Who? _______________	Comments _______________
Cholesterol	Who? _______________	Comments _______________
Diabetes	Who? _______________	Comments _______________
Heart	Who? _______________	Comments _______________
Hypertension	Who? _______________	Comments _______________
Mental Health Problems	Who? _______________	Comments _______________
Ophthalmology	Who? _______________	Comments _______________
Skin/Eczema	Who? _______________	Comments _______________
Stomach Problems	Who? _______________	Comments _______________
Thyroid	Who? _______________	Comments _______________
Urinary Problems	Who? _______________	Comments _______________

Additional Family History/Comments ______________________________________