



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 special 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 _____		