TANNER CLINIC

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 _____

Hospital _____

Did mother have any problems during pregnancy?

Explain _____

Was the delivery Vaginal Cesarean

If Cesarean, why? _____

Did your baby have any problems right after birth?

Explain _____

Any Jaundice?

Explain

Did mother experience problems during labor and delivery?

Explain _____

What medications were taken during pregnancy?_____

Any Drugs/Alcohol/Tobacco?

Group B Strep Positive Negative

If positive, antibiotics given? Doses? _____

Hep B Given? Blood Type _____

Was initial feeding Breast Milk? Formula?

Passed Hearing Screen

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 _____