

Confidential

Easton Family Practice
Infants/Children Health History

PATIENT:

BIRTHDATE

Birth History:

Hospital Name:

Term (37-42 weeks) Pre-term (<37weeks) post-term (>42weeks)

Birth weight: Birth Length:

Problems during pregnancy/delivery:

Diet: Formula: Food:

Past Medical History

Medication

ALLERGIES

Habits

Smoking:
Drugs/Alcohol:

Pharmacy Name:

Pharmacy Phone:

Hospitalization or Surgery:

Table with 4 columns: Date, Reason, Date, Reason. Contains 3 empty rows for data entry.

Immunization History: (please provide us with a list of all immunizations and we will fill out the information on our immunization form)

Family History:

Family History grid with columns for Father, Mother, Children, Siblings and rows for various conditions like Alcoholism, Asthma, Diabetes, etc.

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors or omissions that I may have made in the completion of this form.

I authorize Easton Family Practice Physicians and Staffs to examine, treat, immunize and perform necessary procedures on my dependent.

Guardian Signature Date

Reviewed By