

**Carlsbad Village Family Practice Medical Associates Inc.**

**Past Medical History/ Illness:**

---

---

---

---

---

**List all current medications and dosage:**

---

---

---

---

---

**List all Surgeries/Hospitalizations:**

---

---

---

---

---

**Family History: General health, if deceased, at what age and cause:**

Father: \_\_\_\_\_  
Mother: \_\_\_\_\_  
Siblings: \_\_\_\_\_

**Immunizations / Date of last vaccine:**

Tetanus/Pertussis \_\_\_\_\_  
TB/Tuberculosis \_\_\_\_\_  
Flu Vaccine \_\_\_\_\_  
Pneumococcal Vaccine \_\_\_\_\_

**Social History/habits:**

Have you ever used any of the following? If so, how often?

Tobacco: \_\_\_\_\_  
Alcohol : \_\_\_\_\_  
Coffee: \_\_\_\_\_  
Other: \_\_\_\_\_

**Is there anything in particular you would like to discuss with the doctor?**

**Health concerns or questions?** \_\_\_\_\_

---

---