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? _____

_____