Oberlander and Associates
Internal Medicine, Inc.

Adult Medical History Update Form

Patient Name:_____ Date:_____

Since your last physical exam please list any changes to the following:

Social History	Yes	No
Do you or did you ever use tobacco?		
Do you or did you ever drink alcohol?		
Do you drink caffeinated products?		
Do you or did you ever use illicit drugs?		
Do you work outside the home?		

Have there been any changes in your medical history or that of a family member? ❒No (check box) If yes , please mark below.

Family History-Use check mark	Self	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Sisters	Brothers	Children
Deceased										
Hypertension										
Heart disease										
Stroke										
Kidney disease										
Obesity										
Genetic disorder										
Alcoholism										
Liver disease										
Depression/Anxiety										
Colorectal Cancer										
Prostate Cancer										
Breast Cancer										
Cancer										

Hospital Visits in the last past year visit- list reason Check box if No hospitalizations ❒	Month of visit	Hospital name

Name:_____ Date:_____

Are any other physicians involved in your care?

List the names of other physicians that you see	List condition you are being treated for

When was your last -?

Preventative Screening Exams/Immunizations	Date exam done
Colonoscopy	
Eye Exam	
Foot Exam- if diabetic	
Bone Density	
Pneumonia Vaccine	
Flu Vaccine	
FOR FEMALES:	
Mammogram	
Pap	
FOR MALES:	
Prostate Exam	

No Allergies ❒ (check box if no known medication allergies)

Medication ALLERGIES- list medication	Type of reaction

No Medications ❒ (check box if you are not taking any medications)

Current Medications- include dose and frequency	Name of Prescribing Doctor if other than our office