



ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

**ADULT
HEALTH HISTORY**

Page 1 of 2

Patient Identification

During my visit I would like to talk to my provider about research opportunities:

- Clinical trial
- Tissue Banking
- Melanoma Community Registry

REASON FOR VISIT: _____

PREFERRED PHARMACY: _____

ALLERGIES (please include reaction) _____

- Allergic to latex
- Allergic to lidocaine

ALL Current Medications (including naturopathic) and dosage: Please use separate page list if necessary.

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |

Are you currently taking Vitamin E Anti-inflammatories Blood thinners Aspirin

Do you take Antibiotics before dental work? Yes No

Current lotions / creams / topical medications _____

Review of systems: Have you recently had any of the following

- | | | | |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Headache | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Mood change |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Joint/bone pain | <input type="checkbox"/> Nausea/vomiting | |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Genital/mouth ulcers | |

Health History: Current and past health problems	Yes	No	Explain:
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SKIN DISEASE / DISORDERS

Skin Cancer - type/Location Yes No _____

Personal or family history of other skin disease Yes No _____

Family history of Skin cancer? Type? Yes No _____

Personal history of mole biopsies/Atypical moles Yes No _____

Childhood Eczema / Atopic Dermatitis Yes No _____

Hay Fever/Seasonal Allergies Yes No _____

Family History of Eczema/Allergies/Asthma Yes No _____

During the past 12 months have you been told by a doctor or other health care provider that you have eczema or any kind of skin allergy? Yes No _____

Psoriasis Yes No _____

Scar/history of keloids Yes No _____

Autoimmune disease Yes No _____

(Scleroderma, rheumatoid arthritis, lupus, _____

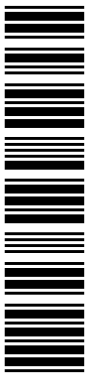
Dermatomyositis, or other) Yes No _____

Eye problems / disorders Yes No _____

Ears, Nose, or Throat problems/disorders Yes No _____

Gastrointestinal disease/problems Yes No _____

PLEASE COMPLETE BACK SIDE OF FORM





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	Yes	No	Explain:
<u>Respiratory disease / disorders</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
COPD/Emphysema/Asthma			
<u>Renal (Kidney) Disease / problems</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Genital / urinary problems</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Cardiovascular (heart disease)</u>			
Angina / Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prosthetic Valve	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Hepatic (Liver) Disease/Problems</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis / B OR C	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Cancer (other than skin cancer)</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Muscle or Bone Disorders/Disease</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Artificial Joint / Date of Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis (type?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Neurological Disorders/problems</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Transplant</u>	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____ Year: _____
<u>Endocrine disease (type?)</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Psychiatric Disease/disorder</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>HIV / AIDS</u>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<u>Social History:</u>			
Occupation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	_____ how often
Tobacco use (current)	<input type="checkbox"/>	<input type="checkbox"/>	_____ pk/day
Tobacco use (past)	<input type="checkbox"/>	<input type="checkbox"/>	_____ pk/day
Other drugs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you currently pregnant / breastfeeding?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you live alone?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you married?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do you have children?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other health problems/concerns	<input type="checkbox"/>	<input type="checkbox"/>	_____

Significant family medical history

Patient Signature: _____ Date: _____

Reviewed By: _____ Date: _____