Oregon Health & Science University
Hospitals and Clinics
Department of Dermatology

ADULT HEALTH HISTORY

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

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

☐ Fever	☐ Headache	☐ Abdominal pain	☐ Cough
☐ Chills	☐ Dizziness	☐ Diarrhea	☐ Mood change
☐ Night sweats	☐ Joint/bone pain	☐ Nausea/vomiting	
☐ Unexplained weight loss	☐ Vision Changes	☐ Genital/mouth ulcers	

Health History: Current and past health problems	**Yes**	**No**	**Explain:**
SKIN DISEASE / DISORDERS			
Skin Cancer - type/Location	☐	☐	_____
Personal or family history of other skin disease	☐	☐	_____
Family history of Skin cancer? Type?	☐	☐	_____
Personal history of mole biopsies/Atypical moles	☐	☐	_____
Childhood Eczema / Atopic Dermatitis	☐	☐	_____
Hay Fever/Seasonal Allergies	☐	☐	_____
Family History of Eczema/Allergies/Asthma	☐	☐	_____
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?	☐	☐	
Psoriasis	☐	☐	_____
Scar/history of keloids			
Autoimmune disease	☐	☐	_____
(Scleroderma, rheumatoid arthritis, lupus, Dermatomyositis, or other)	☐	☐	_____
Eye problems / disorders	☐	☐	_____
Ears, Nose, or Throat problems/disorders	☐	☐	_____
Gastrointestinal disease/problems	☐	☐	_____

OC4501

PLEASE COMPLETE BACK SIDE OF FORM

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

Significant family medical history

_____

_____

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **Date:**_____