Oregon Health & Science University
Hospitals and Clinics
Department of Dermatology

ADULT HEALTH HISTORY

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Please fill out as completely as possible and bring with you on the day of your appointment

Name ____________________ **Birthdate** ____________________
Home Telephone ____________________ **Work Telephone** ____________________
Referring Physician ____________________ **Phone** ____________________
Address ____________________
Primary Care Physician ____________________ **Phone** ____________________
Address ____________________
Pharmacy ____________________ **Phone** ____________________

REASON FOR VISIT: ____________________

ALLERGIES (please include reaction) ____________________
Allergic to latex? _________ **or** **lidocaine?:** ___________

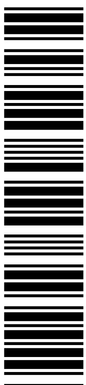
ALL Current Medications and dosage: Please use separate page for medication list if necessary.

1. ____________________ 2. ____________________
3. ____________________ 4. ____________________
5. ____________________ 6. ____________________
7. ____________________ 8. ____________________

Are you currently taking Vitamin E, Anti-inflammatories, blood thinners, Aspirin? (please circle)

Do you take Antibiotics before dental work? ___ **Yes** ___ **No**
Current lotions / creams / naturopathic medications: ____________________

Health History: Current and past health problems	Yes	No	Explain:
General symptoms, such as: fever, weight loss, chills, sweats, or loss of appetite?	____	____	____________
SKIN DISEASE / DISORDERS	____	____	____________
Childhood Eczema / Atopic Dermatitis	____	____	____________
Hayfever	____	____	____________
Psoriasis	____	____	____________
Skin Cancer (type?) (location)	____	____	____________
Scar/history of keloids	____	____	____________
Eye problems / disorders	____	____	____________
Ears, Nose, or Throat problems/disorders	____	____	____________
Gastrointestinal disease/problems	____	____	____________
Respiratory disease / disorders	____	____	____________
COPD/Emphysema	____	____	____________
Asthma	____	____	____________
Cancer	____	____	____________
Renal (Kidney) Disease / problems	____	____	____________
Genital / urinary problems	____	____	____________
Dialysis	____	____	____________



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- continued on reverse -

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	Yes	No	Explain:
Cardiovascular			
Angina / Heart Attack	____	____	____
Valve Disease/ Murmur	____	____	____
Prosthetic Valve	____	____	____
Rheumatic Fever	____	____	____
Hypertension	____	____	____
Arrhythmia	____	____	____
Pacemaker	____	____	____
Peripheral Vascular Disease	____	____	____
Hepatic (Liver) Disease/Problems	____	____	____
Hepatitis / Jaundice	____	____	____
Decreased function	____	____	____
Cancer (other than skin cancer)	____	____	____
Muscle or Bone Disorders/Disease	____	____	____
Artificial Joint / Date of Surgery	____	____	____
Arthritis(type?)	____	____	____
Neurological Disorders/problems	____	____	____
Seizure	____	____	____
Pre-existing nerve damage at site to be treated?	____	____	____
Autoimmune disease (scleroderma, rheumatoid arthritis, lupus, dermatomyositis, or other)	____	____	____
Transplant	____	____	Type:______ Year:______
Endocrine disease (type?)	____	____	____
Diabetes	____	____	____
Thyroid	____	____	____
Psychiatric Disease/disorder	____	____	____
HIV / AIDS	____	____	____
Are you currently pregnant / breastfeeding?	____	____	____
Last menstrual period, if applicable	____	____	____
Social History:			
Occupation: Past and Present	____	____	____
Please list materials you are in contact with			____
Alcohol use	____	____	____ how often
Tobacco use	____	____	____ pk/day
Live alone?	____	____	____
Any other health problems/concerns	____	____	____

Significant family medical history/skin cancer

____

____

Patient Signature: ______________________ Date __________

Reviewed by: ______________________ Date __________