ADULT HEALTH HISTORY
Page 1 of 2

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 ☐ ☐

PLEASE COMPLETE BACK SIDE OF FORM
ADULT HEALTH HISTORY

<table>
<thead>
<tr>
<th>Patient Identification</th>
<th>Yes</th>
<th>No</th>
<th>Explain:</th>
</tr>
</thead>
</table>

**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
- Tobacco use (current)
- Tobacco use (past)
- 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: __________