UNIQUE
Dermatology & Wellness Center
WHERE BEAUTY & HEALTH MEET

PATIENT MEDICAL HISTORY

PATIENT NAME:_____
DATE:_____

REASON FOR VISIT:_____

PHARMACY NAME:_____ **PHONE #:**_____

PHARMACY ADDRESS:_____

Past Medical History: (Please circle all that apply)

NONE	COPD	High Cholesterol
Anxiety	Coronary Artery Disease	Hyperthyroidism
Arthritis	Depression	Hypothyroidism
Asthma	Diabetes	Leukemia
Atrial Fibrillation	End Stage Renal Disease	Lung Cancer
Bone Marrow Transplantation	GERD (reflux)	Lymphoma
BPH (enlarged prostate)	Hearing Loss	Prostate Cancer
Breast Cancer	Hypertension	Radiation Treatment
Colon Cancer	HIV/AIDS	Stroke
Other:		

Past Surgical History: (Please circle all that apply)

NONE	Heart Transplant	Prostate Removed: Prostate Cancer
Appendix Removed	Heart: Mechanical Valve Replacement	Prostate Biopsy
Bladder Removed	Heart: Angioplasty/Stent	TURP (Prostate Removed)
Breast Biopsy	Joint Replacement: Hip Rt/ Lf/Both	Skin Cancer Surgery: Basal, Squamous, Melanoma
Breast: Lumpectomy- Rt/Lf/ Both	Kidney Biopsy	Spleen Removed

Breast:Mastectomy -Rt/ Lf/ Both	Kidney Stone Removal	Testicles Removed
Breast Implants	Kidney Transplan t	Hysterectomy: Fibroids
Colectomy: Colon Cancer Resection	Kidney Removed	Hysterectomy: Uterine Cancer
Colectomy: Diverticulitis	Liver Transplant	Hysterectomy: Cervical Cancer
Colectomy: IBD	Ovaries Removed: Endometriosis	
Gallbladder Removed	Ovaries Removed: Ovarian Cancer	
Heart: Biological Valve Replacement	Ovaries Removed: Ovarian Cyst	
Heart: Coronary Artery Bypass	Ovary: Tubal Ligation	
Other:		

Skin Disease History: (Please circle all that apply)

NONE	Dry Skin	Precancerous Moles
Acne	Eczema	Psoriasis
Actinic Keratosis	Flaking or Itchy Scalp	Squamous Cell Skin Cancer
Asthma	Hay Fever/ Allergies	
Basal Cell Skin Cancer	Melanoma	Other:
Blistering Sunburns	Poison Ivy	

Do you wear sunscreen? **Yes** **No** **If yes, what SPF?** _____

Do you tan in a tanning salon? **Yes** **No**

Do you have a family history of Melanoma? **Yes** **No** **If yes, which relative(s)?** _____

Medications: (Please list all current medications) ☐ **NO MEDICATIONS**

_____

_____

_____

Allergies: (Please list all allergies) ☐ **NO KNOWN DRUG ALLERGIES**

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking: Never smoked / Quit: former smoker / Smokes:_____cigarettes a day_____yrs.

Alcohol Use: None / If Yes, How many drinks a day?_____ Beer / Wine / Liquor

Caffeine Intake: How many glasses/cups a day? Tea_____ Coffee _____Soda_____

Sexual History: Not sexually active / Active with one partner / Active with multiple partners

Safety: I feel safe at home / I do not feel safe at home

Patients 65 yrs. Of age or older only: I have / I have not received a Pneumonia vaccine

I have / I have not received an Influenza vaccine

I have a Living Will: Yes No

Family History: (Only first degree relatives)

Asthma: _____**Heart Disease:**_____

Thyroid Disease:_____**Skin Cancer:**_____

Hypertension:_____
Diabetes:_____

Mental Illness:_____ **Other Cancers:**_____

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Review of Systems: Are you currently experiencing problems with any of the following? (Please circle any positive answers).

Constitutional: Chills / Fatigue / Fever / Unintentional Weight Gain / Unintentional Weight Loss

HEENT: Blurred Vision / Sensitivity to Light /

Cardiovascular: Rapid Heartbeat / Leg Swelling / Chest Pain / Shortness of Breath

Genitourinary: Genital Lesions / Urinary Frequency / Pain with urination / Loss of Urine with coughing

Musculoskeletal: Joint Aches / Muscle Aches / Muscle Weakness

Skin: Rashes / Itching / Sensitivity to Light

Neuro: Weakness / Dizziness / Tingling / Loss of Skin Sensation / Seizures / Headaches

Heme: Excessive Bruising / Prolonged Bleeding

Endo: Hair Loss / Excessive Hair Growth / Excessive Sweating / Thyroid

Allergy: Hay Fever / Hives

Psy: Depression / Suicidal Thoughts / Anxiety

GI: Abdominal Pain / Bloody Stool

Pulm: Shortness of Breath / Cough / Wheezing

PATIENT (Print Name):_____
DATE:_____

PATIENT,PARENT,GUARDIAN(Signature):_____