MISSISSIPPI DERMATOLOGY ASSOCIATES

1006 TREETOPS BLVD., SUITE 101
FLOWOOD, MISSISSIPPI 39232
(601) 939-0005 Fax (601) 936-4949

PATIENT NAME: _____

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Other: _____

ETHNICITY: ❑ Not Hispanic/Latino ❑ Hispanic/Latino

RACE: ❑ American Indian ❑ Asian ❑ African American ❑ White ❑ Other: _____

PHARMACY:_____ **CITY:**_____ **LOCATION:**_____

DO YOU CURRENTLY HAVE: (CHECK YES OR NO)

Problems	Y	N	Problem	Y	N	Problem	Y	N
Problems with bleeding	❑	❑	Abdominal Pain	❑	❑	Allergy to Adhesive	❑	❑
Problems with healing	❑	❑	Joint Aches	❑	❑	Allergy to Lidocaine	❑	❑
Problems with Scarring	❑	❑	Muscle Weakness	❑	❑	Allergy to topical antibiotic ointments	❑	❑
Rash	❑	❑	Headaches	❑	❑	Artificial heart valve	❑	❑
Immunosuppresion	❑	❑	Seizures	❑	❑	Artificial joints within the past two years	❑	❑
Hay fever	❑	❑	Cough	❑	❑	Blood thinners	❑	❑
Chest pain	❑	❑	Shortness of Breath	❑	❑	Defibrillator	❑	❑
Fever or chills	❑	❑	Wheezing	❑	❑	MRSA	❑	❑
Night sweats	❑	❑	Anxiety	❑	❑	Pacemaker	❑	❑
Unintentional weight loss	❑	❑	Depression	❑	❑	Premedication prior to procedures	❑	❑
Thyroid Problems	❑	❑				Rapid heartbeat with Epinephrine	❑	❑
Sore Throat	❑	❑				Pregnancy or planning a pregnancy	❑	❑
Blurry Vision	❑	❑				Allergy to Latex	❑	❑

Alcohol	Yes ❑	No ❑	If yes, how much per day?	_____
Do you smoke	Yes ❑	No ❑	If yes, how much per day?	_____
Former smoker	Yes ❑	No ❑		
Sunscreen	Yes ❑	No ❑	If yes, what strength?	_____
Tanning Bed	Yes ❑	No ❑	If yes, how often?	_____

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Have you had in the past or are presently having a problem with:

Condition	Yes
Anxiety	
Arthritis	
Asthma	
Atrial Fibrillation (Irregular heartbeat)	
Bone Marrow Transplantation	
Breast Cancer	
Colon Cancer	
COPD/Pulmonary Disease	
Coronary Artery Disease	
Depression	
Diabetes	
End Stage Renal Disease	
Enlarged Prostate	
GERD/Reflux	
Hearing Loss	
Hepatitis	
High Blood Pressure	
HIV/AIDS	
High Cholesterol	

Condition	Yes
Hyperthroidism	
Hypothroidism	
Leukemia	
Lung Cancer	
Lymphoma	
Prostate Cancer	
Radiation Treatment	
Seizures	
Stroke	
Anemia/Bleeding Disorder	
Blood Clots in lungs	
Chronic Headaches	
Gallbladder Disease	
Heart Attack	
Inflamed Pancreas	
Kidney Problems	
Pacemaker	
Phlebitis	
Sickle Cell Disease	

Any other medical problems not listed above? _____

Check if you have a previous history of: ❑ Basal Cell ❑ Squamous Cell ❑ Melanoma
Other _____

Do you have allergies to any drugs, food, ointments, creams, make-up, jewelry? ❑ Yes ❑ No
If yes, please list _____

Have you had surgery in the last three years? ❑ Yes ❑ No
If yes, why? _____

Are you currently taking an aspirin daily? ❑ Yes ❑ No

Are you currently taking a blood thinner daily? ❑ Yes ❑ No If yes, what medication?:
_____

Are you currently taking any other medication daily? ❑ Yes ❑ No If yes, please list:

_____ _____ _____ _____

_____ _____ _____ _____