SAUL DERMATOLOGY

5002 Highway 39 N Bldg. A
Meridian, MS 39301
Phone: 601-512-0500 Fax: 601-512-0505

Established Patient Form

Date: _____

Patient Information

Name: _____ Date of Birth: _____/_____/_____ Age: _____
Pharmacy: _____ Height: _____ Weight: _____
Allergies: _____

Reason for Return Visit:

___ Doctor scheduled follow up
___ New Problem, is so please list: _____

Recent changes in Medical History -Please circle all that apply:

Melanoma	Diabetes	Glaucoma	Stroke
Skin Cancer	High Blood Pressure	Liver Problems	Tuberculosis
Stomach Ulcer	Kidney Problems	Thyroid	Seizures
Tumor	High Cholesterol	Anemia	Recent Illness/Infection
Cancer	Heart Trouble	Arthritis	

Other Issues:_____

Recent Surgeries:_____

New Medications: _____

Any new symptoms that you are experiencing? – Please circle all that apply:

Rash	Stomach Pain	Chest Pain
Itching	Change in Urination	Shortness of Breath
Other skin changes	Change in Stool	Bruising Easily
Headache	Muscle Pain	Depression
Vision Changes	Joint Pain	

Other Issues: _____

For Females:

Are you pregnant? Yes/No
Trying to become pregnant? Yes/No
Breastfeeding? Yes/No

_____ _____ _____
Signature of patient or authorized person | Relationship to patient | Date