SAUL DERMATOLOGY

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

Surgical Intake History Form

Patient Information

Name: _____ Date of Birth: _____/_____/_____ Height: _____ Weight: _____
Do you smoke? Yes No If Yes, _____ packs per day for _____ years.
Are you currently taking Aspirin? Yes No If Yes, what strength? 81 mg 325 mg
Are you currently taking any other blood thinners? (Please list) _____
Allergies: _____

Past Medical History – Please circle all that apply:

AIDS virus/HIV	Chest Pains	Heart Attack	Rheumatic Fever
Aneurysm	Other Skin Cancers	High Blood Pressure	Diabetes
Asthma	Seizures	Irregular Heart Beats	Hepatitis
Bleeding Disorder	Emphysema	Keloids/Abnormal Scars	
Prolonged Bleeding	Fever Blisters/Herpes	Lupus/Autoimmune disease	

Other Conditions:_____

Past Surgical History – Please circle all that apply:

Artificial Heart Valves	Bypass Surgery	Prosthesis	Vascular Surgery
Artificial Joints	Pacemaker	Transplant	

Other Surgeries:_____

Review of Systems – Please circle if you have problems now or have had within the past year

Chest Pain	Gastrointestinal	Musculoskeletal	Skin
Ears/Nose/Mouth	Genitourinary	Neuro/Seizures	Comments: _____
Endocrine	Heart	Psychiatric	_____
Eyes	Hematologic	Respiratory	_____

Medications – Please list all medications including dosage if known

_____
_____
_____

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