DERMATOLOGY - SOUTH
HATTIESBURG CLINIC

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Name:

Date of Birth: _____

History #: _____

Physician: _____

LABEL

Medical History Questionnaire: *(Please print)*

Date: ____/____/____

Patient's Name _____ Age____
FIRST MIDDLE LAST

Name you wish to be called _____ Date of Birth: ____/____/____ Race_____
Mo. Day Yr.

Marital Status (Circle One) Single Married Widowed Gender (Circle One) M F

Employment status (Circle One) Student Employed Self-employed Unemployed Retired Disabled

Place of Employment or School Attending _____

Job Title & Occupation (what you do) _____

PAST MEDICAL HISTORY: CHECK ANY OF THE PROBLEMS LISTED BELOW THAT YOU HAVE (OR HAVE HAD)			**SURGICAL HISTORY** Type of Surgery	**YEAR**
___ Emphysema	___ High Blood Pressure	___**Tanning bed use**		
___ Arthritis	___ Kidney Disease	___Tuberculosis		
___ Asthma	___ Liver Disease	____Other (list below)		
___ Bleeding Tendency	___ **Melanoma**	_____		
___ Cancer	___ Peptic Ulcers	_____		
___ Diabetes	___ Seizures	_____		
___ Heart Disease	___ **Skin Cancer**	_____		

REVIEW OF SYSTEMS	____ Cough	____ Sore Mouth	____ Blurry Vision	____ Hair Loss
____ Fever	____ Sore Joints	____ Shortness of Breath	____ Itchy Skin	____ Other
____ Weight Loss	____ Sore Muscles	____ Nausea, Vomiting	____ Sun Sensitivity	_____
____ Tiredness	____ Headaches	____ Diarrhea	____ Burning of Skin	_____

PLEASE CIRCLE YES OR NO AND EXPLAIN IF NECESSARY

1. Were you referred to this clinic by a doctor? YES NO
   If yes, show name and city. _____
2. Who is your primary care or family provider?
   _____
3. Have you seen a dermatologist before? YES NO
   If yes, show name and city. _____
4. Have you had previous treatment for your current skin problem? By whom? YES NO
   _____
5. Does anyone in your family have skin problems or rashes? YES NO
   _____
6. Are you under medical treatment of any other condition? (Explain if not already listed in electronic medical record) YES NO
   _____
7. Are you known to be a carrier of any contagious disease? Explain YES NO
   _____
8. Do you smoke? YES NO
9. Do you drink alcohol? YES NO
10. Do you take any medications currently? YES NO
11. Are all of your medications listed and up to date in the Hattiesburg Clinic electronic medical records? YES NO
    IF NOT, LIST OR UPDATE MEDICATIONS BELOW:
12. **Are you known to be <u>allergic</u> to any <u>medications</u>?**
    YES NO SEE ELECTRONIC MEDICAL RECORD
    If <u>yes</u>, please list: _____

For Women Only: Are you pregnant? YES NO **Are you breastfeeding**? YES NO **Do you take Birth Control Pills?** YES NO

PATIENT SIGNATURE **PHYSICIAN/PROVIDER SIGNATURE**

1 3 4 7 6

(9/2024)