Messenger Dermatology
A DIVISION OF COMPASS HEALTH

Patient Registration

Welcome to Messenger Dermatology! Please complete each page and return your completed form to the front desk as soon as you're done. We are happy to answer any questions.

Personal Information

Date: ____/____/_____

Name:

_____

Date of Birth:

____/____/_____

Marital Status:

❑ Married ❑ Single

❑ Widowed ❑ Divorced

Gender:

❑ Male ❑ Female

Address: _____ **Apt/Unit:** _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone:

( ) _____ ❑ Home ❑ Work ❑ Cell

Is it OK to leave a detailed message at this number? ❑ Yes ❑ No

Secondary Phone: ❑ Home ❑ Work ❑ Cell

( ) _____

Email Address: _____

Employment:

Employer: _____ Occupation:_____

Emergency Contact Information

Please provide an emergency contact along with authorization to share medical information with that person.

Name:	**Relationship:**	**Phone:**
_____	_____	**( ) _____**

Do we have your permission to share medical results/information with the contact listed above? ❑ Yes ❑ No

Preferred Pharmacy and Primary/Referring Doctor

Please provide the contact information for both your preferred pharmacy, as well as your primary care doctor and referring doctor.

Primary Care Doctor: _____

Referring Doctor: _____

Preferred Pharmacy: (Include city and street or street intersection):

Name: _____ City/Street: _____

Phone: _____

Do we have your permission to obtain your medication list from your pharmacy? ❑ Yes ❑ No

Medications:

*Please list below **(name/dosage/frequency)*** or *provide us your medication list.*

Medication	Dosage	Frequency

Medication Allergies/Reactions

Please list all allergies to medications, as well as your reaction.

_____

Past Medical History (check all that apply):

- ❑ Asthma
- ❑ Bone Marrow Transplant
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Depression
- ❑ Diabetes
- ❑ End-Stage Renal Disease (Kidney Failure)
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV/AIDS
- ❑ Hy**PER**thyroidism
- ❑ Hy**PO**thyroid
- ❑ Inflammatory Bowel Disease
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Organ Transplant
- ❑ Other:

Have you had any of the following skin conditions? (*check all that apply*)

- ❑ Basal Cell Cancer (If yes, when? _____)
- ❑ Squamous Cell Cancer (If yes, when? _____)
- ❑ Precancerous moles (atypical nevi)
- ❑ Melanoma (If yes, when? _____)
- ❑ Psoriasis
- ❑ Eczema
- ❑ Hay fever/Allergies

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

Are you a smoker? ❑ Never ❑ Former ❑ Currently

Number of packs/day: _____ **Total Number of Years Smoking: _____**

Are you currently experiencing any of the following: *(Please check all that apply)*:

- ❑ Problems With Healing (Keloids Or Slow Wound Healing)
- ❑ Immunosuppression (Related To A Medication Or Leukemia/Lymphoma)
- ❑ Hay Fever/Seasonal Allergies
- ❑ Fever Or Chills
- ❑ Joint Aches (New Within Past 6 Months)
- ❑ Muscle Weakness Or Spasms (New Within Past 6 Months)
- ❑ Chest Pain
- ❑ Headaches (Occurring Daily For Months, Not Just Occasionally)
- ❑ Shortness Of Breath (New Onset, Not Chronically Occurring)
- ❑ New And Persistent Abdominal Pain, Diarrhea Or Blood In Stool
- ❑ Thyroid Problems
- ❑ Allergy To Lidocaine
- ❑ Artificial Joint(s) Within Past Two Years
- ❑ Pacemaker
- ❑ Pregnancy Or Planning A Pregnancy