MRN

Name

DOB

Patient stamp or label above

UNIVERSITY CLINICAL HEALTH
Dermatology

930 Madison Avenue, Suite 801
Memphis, Tennessee 38103 – 3410
P 901.866.8790 | F 901.302.2790

Return Patient Questionnaire

What is the best contact phone number for you? _____

Primary Care Physician: _____ Referred by: _____

Reason for your visit today? _____

Current Medications (use back if needed): _____

_____

Pharmacy Name and Phone Number: _____

Drug Allergy / Other Allergies (including latex, tape, sutures, etc.): _____

_____

Are you experiencing any of the following? (Check all that apply)

- ❒ Chills
- ❒ Fatigue
- ❒ Fever
- ❒ Night sweats
- ❒ Weakness
- ❒ Weight gain
- ❒ Weight loss
- ❒ Dry skin
- ❒ Itching
- ❒ Nail changes
- ❒ Mouth sores
- ❒ Light sensitivity
- ❒ Anxiety
- ❒ Headache
- ❒ Depressed mood
- ❒ Suicidal thougths
- ❒ Blurred vision
- ❒ Burning eyes
- ❒ Decreased night vision
- ❒ Dry eyes
- ❒ Sinus pain
- ❒ Tearing
- ❒ Vision changes
- ❒ Cough
- ❒ Wheezing
- ❒ Chest pain
- ❒ Swelling
- ❒ Palpitations
- ❒ Varicose Veins
- ❒ Abdominal pain
- ❒ Constipation
- ❒ Diarrhea
- ❒ Heart burn
- ❒ Nausea
- ❒ Vomiting
- ❒ Dark urine
- ❒ Irregular menstrual cycle
- ❒ Cold intolerance
- ❒ Heat intolerance
- ❒ Arthritis
- ❒ Muscle spasms
- ❒ Muscle weakness
- ❒ Blood clots
- ❒ Easy bleeding
- ❒ Easy bruising
- ❒ Enlarged lymph nodes
- ❒ Food allergies
- ❒ Environmental allergies

(Female patietn only)
Are currently, or any chance you could be pregnant? _____

FOR OFFICE USE ONLY

Ht: _____ in. Wt: _____ lbs. Temp: _____ °F BP: _____ /_____ HR: _____ bpm R: _____ bpm

New Patient: ❒ Yes ❒ No ❒ M ❒ F ❒ Full Exam ❒ Focused Exam ❒ Gown

> 18 yo ❒ Yes ❒ No Parent / guardian present or consent ❒ Yes ❒ No

Resident physician consent ❒ Yes ❒ No