

**Dermatology Patient Questionnaire**

To help us to provide you with the best possible care, please fill out the information below.

Name of physician who requested consultation: \_\_\_\_\_

	<b>Problem # 1</b>	<b>Problem # 2</b>	<b>Problem # 3</b>
<b>Please describe your skin problem.</b> (e.g. rash, "bump", sore, symptom, etc.):			
<b>Where is it located on your body?</b>			
<b>When did it appear?</b>			
<b>Is your problem mild, moderate or severe?</b>			
<b>How does it feel?</b> (e.g. itching, burning, painful, no symptoms at all, etc.)			
<b>What if anything is making your problem BETTER?</b>			
<b>What if anything is making your problem WORSE?</b>			
<b>How did you try to treat you problem?</b>			
<b>Results</b> (check the appropriate box):	<input type="checkbox"/> <i>not applicable</i> <input type="checkbox"/> <i>resolved</i> <input type="checkbox"/> <i>improved</i> <input type="checkbox"/> <i>unchanged</i> <input type="checkbox"/> <i>worse</i>	<input type="checkbox"/> <i>not applicable</i> <input type="checkbox"/> <i>resolved</i> <input type="checkbox"/> <i>improved</i> <input type="checkbox"/> <i>unchanged</i> <input type="checkbox"/> <i>worse</i>	<input type="checkbox"/> <i>not applicable</i> <input type="checkbox"/> <i>resolved</i> <input type="checkbox"/> <i>improved</i> <input type="checkbox"/> <i>unchanged</i> <input type="checkbox"/> <i>worse</i>

**Please list your medical conditions (illnesses), including past skin cancers:**

**Please list your medications:**

**Has anyone in your family had skin cancer, eczema, psoriasis or lupus?**

**Do you smoke?**  no  yes: \_\_\_\_\_ **What is your occupation?** \_\_\_\_\_

<b>Do you have (check with <math>\sqrt</math> under NO or YES):</b>	<b>NO</b>	<b>YES (explain if needed)</b>
<b>1. Unexplained weight loss/Fevers/Chills</b>		
<b>2. Vision changes;</b>		
<b>3. Problems w/ears, nose, throat &amp; mouth;</b>		
<b>4. Chest pain;</b>		
<b>5. Shortness of breath/Cough;</b>		
<b>6. Nausea/Vomiting/Abdominal pain/Diarrhea/ Bloody or black stools;</b>		
<b>7. Bloody urine;</b>		
<b>8. Joint or bone pain;</b>		
<b>9. Skin problems.</b>		$\sqrt$ (as above)
<b>10. Headache/Seizures/Muscle weakness;</b>		
<b>11. Depression;</b>		
<b>12. Heat or cold intolerance;</b>		
<b>13. Easy bruising/Prolonged bleeding/Anemia</b>		
<b>14. Are you pregnant or planning pregnancy?</b>		

**15. Allergies (please list):** \_\_\_\_\_

**Physical Exam Permission: Please check the appropriate box**

Our Dermatology clinic strongly recommends that every new and established patient have a complete skin evaluation on initial exam and annually.

**Yes**, I want to have a full skin exam **INCLUDING** the examination of skin covered with underwear.

**Yes**, I want to have a full skin exam **EXCLUDING** the examination of skin covered with underwear, with full understanding that serious skin disease including skin cancer that can result in death can be present on skin that will not be examined.

**No**, I do not want to have a full skin exam with full understanding that serious skin disease including skin cancer that can result in death can be present on skin that will not be examined.

**Medications: Please check the appropriate box**

I understand that any medication, prescription or over-the-counter, even seemingly safe medications can have rare, serious and sometimes unforeseen side effects. If any medication is indicated for treatment of my condition:  **Yes**, I agree to accept that risk.  **No**, I do not agree to accept that risk.

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_