Colorado Mountain Medical
Doctors you know and trust

Dermatology Screening Form

Name: _____ DOB: _____ Age: _____

Have you been seen in this dermatology clinic in the last 3 years? Yes No

What is your primary complaint today (list one only)? _____
(Because of time limitations, this may be the only complaint able to be addressed today.)

Why does it bother you? _____

How long has it been occurring? _____

What treatments in the past, if any, have been prescribed? _____

Do you have SKIN pain or tenderness (not itch) today? Yes No

Please rate 0-10 (0 is none, 10 is the worst pain you've ever felt/can imagine) _____

If you are here for a skin check or concern for possible cancerous lesions, do you have a history of skin cancer? Yes No If yes, please list (date, type, body location, treatment)_____
_____

Do you have a family history of melanoma? Yes No

Do you have a history of tanning/tanning bed use? Yes No

On a scale of 1-5 (1=always, 5= never). How often does your skin burn w/o sunscreen?_____

How often do you use sunscreen/sun protection? _____

Do you have any allergies (drug, food, environmental)? Yes No If yes, please list. _____
_____

What are your chronic (on-going) medical problems? _____
_____

What oral/topical medications do you take (including prescription, over-the-counter medications, supplements and vitamins)? _____
_____

Do you smoke or use tobacco products? Yes No If yes, how much in a day? _____

Do you drink alcohol? Yes No If yes, how many drinks in a day/wk/month? _____

Physician Notes: