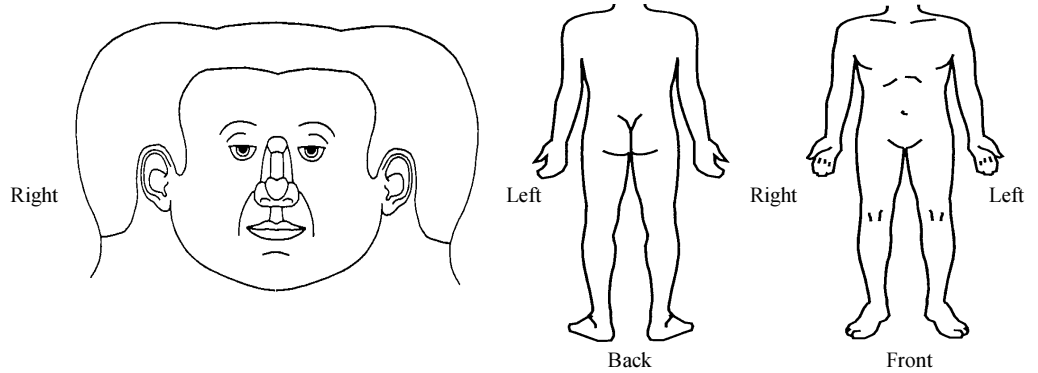


Dermatology
Follow Up History Form
Please circle &/or describe.
Circle the word "None" if nothing applies

Date Name Age Date of Birth Date of Last Visit

Chief Complaint Please circle & describe → Same or New Acne Spot Mole Wart Growth Rash Itching &/or other

Drug Allergies: *None* or List below.



Please mark the location
Audiovisual recordings may be made for documentation

1-Problem Please list:

Status: Clear Better Same Worse List:

Treatment Side-effects &/or Complications: *None* or List:

2- Problem Please list:

Status: Clear Better Same Worse List:

Treatment Side-effects &/or Complications: *None* or List:

3- Problem Please list:

Status: Clear Better Same Worse List:

Treatment Side-effects &/or Complications: *None* or List:

Please list any changes in the following categories since your previous visit

Drugs & Allergy History *None* or List:

Medical and Surgical History *None* or List:

Past, Family and Social History *None* or List:

Review of Systems History *None* or List:

Present Skin Diagnoses & Treatments *None* or list:

Past Skin Diagnoses & Treatments *None* or list:

Previous medical records dated reviewed and updated.

Any New Problem: *None* If Yes, please complete a **New Problem History Form** for detailed history.

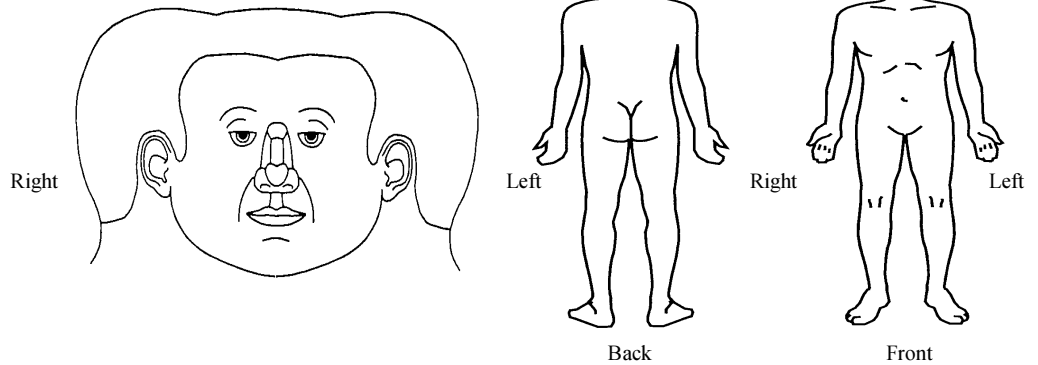
Any other questions or comments: *None* or list:

Dermatology
New Problem History Form
 Please circle &/or describe.
 Circle the word "None" if nothing applies

Date Name Age Date of Birth Languages spoken

Chief Complaint Circle & describe → Acne Spot Mole Wart Growth Rash Itching &/or other Please list below.

Drug Allergies: *None* or List below.



Please mark the location
 Audiovisual recordings may be made for documentation

**Proper Skin Exam usually requires
 partial or complete undressing.
 Please let the staff know
 if you need assistance.**

History of Present Illness:

Problem Please circle Acne Spot Mole Wart Growth Rash Itching &/or other Please list:

Location (*Site-Where?*) Generalized Multiple As marked above or List:

Duration (*How Long? When?*)daysweeksmonthsyears *unknown*

Timing Acute Chronic Persistent Recurrent **Onset** Sudden Gradual

Quality No-Symptoms Itching Irritating Painful Non-Healing Changing Suspicious

Unsightly Bothersome Upsetting &/or list:

Severity Mild Moderate Severe Extensive **Extent** Generalized Localized

Context: Any special Association/Context: *None Unknown* or list:

Modifying Factors

Aggravated by: *None Unknown* Nerves Stress Menses Contact Allergy Plants
 Chemicals Work Sports Hobbies Pets Drugs &/or list:

Improved by: *None Unknown* Meds OTC Home remedies Other Please list:

Associated Signs & Symptoms *None* Itching Pain Abnormal Sensation Weakness
 Other Please list:

Other Signs & Symptoms *None* Psychological Social &/or other list details:

Dermatologists &/or Physicians seen *None* or list details:

Present Skin Diagnoses & Treatments *None* or list details:

Past Skin Diagnoses & Treatments *None* Same or list details:

Any other relevant information *None* or list:

Any other information you wish us to know *None* or list:

Dermatology Exam & Management

Patient Name:

Chaperone/Scribe: Dr. Irum Pasha or List:

Drug Allergies & Contraindications: *None or List*

Date of Birth:

Age:

Date of Exam:

Sex: M F

Constitutional-General Appearance

Build, Nutrition, Posture, Grooming	Normal	Yes	No
Vital Signs Wt. Pulse, BP, Temp			

Neuro/Psychiatric

Alert & Oriented in T/S/P	Normal	Yes	No
Mood and Affect	Normal		

Eyes

Eyelids and Conjunctivae	Normal	Yes	No

Hair & Sweat Glands

Scalp & Body Hair	Normal	Yes	No
Eccrine & Apocrine Glands	Normal		

Skin & Subcutaneous Tissues

Blemishes, Rashes, Lesions, Photodamage etc		Yes	No
Head & Face	Normal		
Neck	Normal		
Chest, Breast & Axillae	Normal		
Abdomen	Normal		
Genitalia, Groin & Butcks	Normal		
Back	Normal		
Right Upper Extremity	Normal		
Left Upper Extremity	Normal		
Right Lower Extremity	Normal		
Left Lower Extremity	Normal		

Cadiovascular (Peripheral)

No edema, Circulation ok	Normal	Yes	No

Extremities

No digital cyanosis or clubbing	Normal	Yes	No

Ear, Nose, Mouth & Throat

Lips, Teeth and Gums	Normal	Yes	No
Oropharynx	Normal		

Neck

Thyroid, nodules or masses	Normal	Yes	No

Lymph Nodes

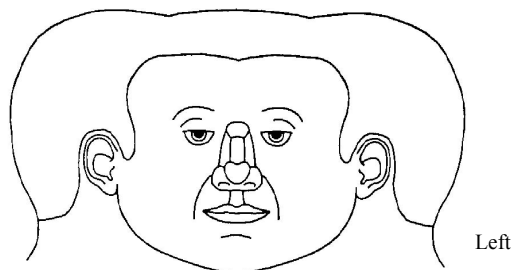
1-Neck 2-Axillae 3-Groin	Normal	Yes	No

Gastrointestinal

No anal growths or fissures	Normal	Yes	No
No hepatosplenomegally	Normal		

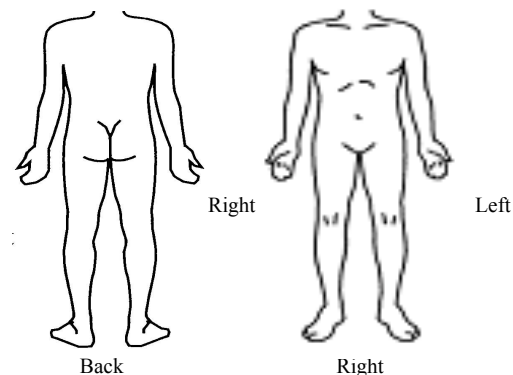
Our Derm Exams are essentially Focused ie Spot Checks only.

Problem Based Exam:- Focused: 1 Expanded: 6 Detailed: 12



Right

Left



Left

Right

Left

Back

Right

Culturally Sensitive Exam - Spot Checks only

Pertinent Details (Photo &/or Audiovisual documentation)

Clinical Impression

Management Plan

KOH C&S Bx Surg CME WorkUp Ref

We provide only limited office based derm diagnostic and therapeutic services.

Follow Up

Week Month PTC PCP REF