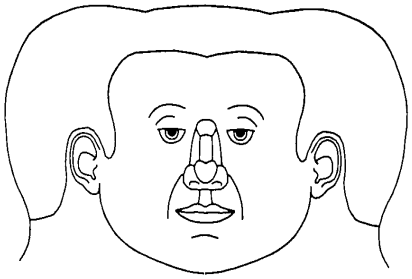
Dermatology
New Problem History Form
Please circle &/or describe.
Circle the word "None" if nothing applies

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.

Right



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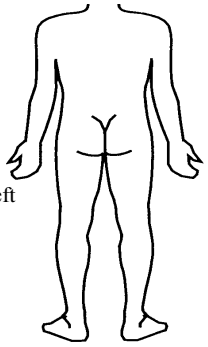

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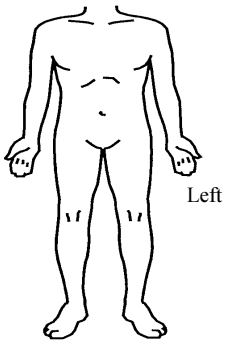


Back Front

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?)* .....days .....weeks .....months .....years *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:

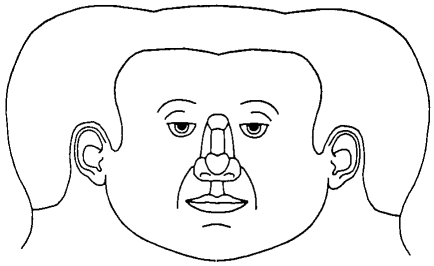
Any other information you wish us to know *None* or list:

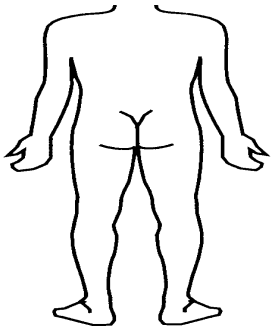
Skin Screening Program

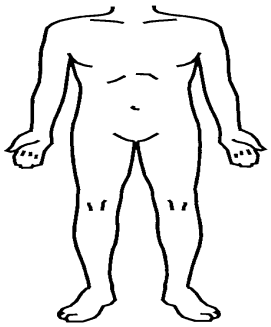
Spot-Check

Date: ..... Skin Spots, Blemishes, Moles, Growths & Other Problems Location: .....

Name: DOB: Age: Tel: email:







Problems / Lesions	1	2	3	4	5
Spot Mark Mole Wart Growth Pain Itching or Other Problems, Please List:					

Location / Where is it?					
What part of body? Please Mark or List:					

Onset / How did it appear?					
Was the onset Sudden or Gradual?					

Duration / How long?					
When did you notice it first?					
Days Weeks Months Years					

Symptoms &/or Change (Yes or No)					
Irritated, Painful, Bleeding, Unsightly: Y/N					
Any *Change* in size shape color etc: Y/N					

Personal &/or Family History		
Any type of Cancer, Melanoma etc	No	If yes, please list:
Other conditions	No	If yes, please list:
Other relevant Information	No	If yes, please list:

Consent to do Spot Check

I know Spot Check is not a substitute for complete Skin evaluation. **Sign:**

I am free to seek full exam & care from any physician of my choice. **Date:**

I release Dr. Khan from any liability in connection with this screening. **Circle:** Patient Parent Legal Guardian

Benign lesions can turn cancerous. Any change → Consult a Dermatologist.

Spot Check Review	1	2	3	4	5
Benign: Any change → Consult a Dermatologist					
Borderline: → Advise Dermatology Visit					
Suspicious: → Advise Diagnostic Testing					

Dr. Khan's Advice

Avoid Unnecessary Sun exposure, Seek Shade, Wear Protective Clothing, Apply Sunscreens & Use UV Blocking Sunglasses regularly.

Any change in a lesion or a new growth should be evaluated as soon as possible. Early detection can be life saving.

The only sure way to differentiate between Benign & Cancerous mole/growth with almost 100% accuracy is by Pathology Examination.

Please seek a dermatology evaluation if you notice any change in your condition, symptoms or develop a new lesion of any type.

Please join us in promoting Sun Protection & offering Skin Cancer Screenings to save lives by making generous donations.

Single Spot-Check is provided free of charge to all deserving persons.

We request a regular dermatology visit for multiple skin spots or problems.

Our goal is to save lives by promoting Prevention, Early Detection & Prompt Treatment of Skin Cancers.

Mushtaq A. Khan, M.D., Board Certified Dermatologist©

Dermatology
Past, Family & Social History Form
List of Current Medications, Drug Allergies & Other Contraindications

Please circle &/or describe.
Circle the word "None" if nothing applies

Name.....**Date**.....

Past and Present Problems *None* Psych/Neuro Depression Memory Alzheimer Seizures Dizzy Spells Headaches Stroke Diabetes Thyroid Hormone ENT Hearing Mouth Teeth High Blood Pressure Cholesterol Heart Disease Heart Attack Irregular Heart Beat Palpitations Murmur MVP Bypass Pacemaker Shortness of Breath Asthma Anemia Lymph Nodes Cancer Arthritis Lupus Muscle Bone Prostate Kidney Urinary Genital Digestive Reflux Gerd Peptic Ulcers Colitis Cataract Glaucoma Allergies Hay fever Hepatitis B C TB HIV STDs Infectious Diseases General Constitution Recent Weight Loss Weight Gain Tired Fever Frail Obese Disabled Radiation Surgeries & others. Please write down all your symptoms & medical problems or provide a list.

Family Hx *None* Adopted Acne Eczema Dermatitis Psoriasis Allergies Drug Reactions Fungus Abnormal Moles Melanoma Skin Cancer Lupus Hair Loss Thyroid Disease Arthritis Diabetes Heart Disease High BP Stroke Seizures Cancer Glaucoma Cataract Keloids Unknown Similar Same &/or Other Hereditary/Familial Disorders. Please list names of all family conditions:

Social Hx **Marital Status:** s m d w **Education &/or Occupation:** Child Student Home Retired Disabled None or list: ……..
Sun Protection yes no **Exercise** yes no **Tobacco** yes no **Alcohol** yes no **Pets** no yes ……..…..… **Hobbies & Sports:** *None* or list:……...……..……..
Foreign Travel no yes ……..……..… **Any exposure to TB, Hepatitis, HIV etc** no yes ……..……..…… **Any other relevant information:** *None* or list:

Surgery Patients High BP Angina Heart-Circulation Irregular Heart Beat Stroke Palpitations Diabetes Infection Fainting Implants Prosthetics Dizzy Spells Blood Thinners Aspirin Arthritis-meds Cortisone Bleeding Poor Healing Lumpy Scars Keloids
Any Reaction to: Lidocaine Anesthetics Epinephrine Antiseptics Band-Aids Tapes Antibiotics *None* &/or others Please list below.

Female Patients **Pregnant** No Yes months **Breast Feeding** No Yes months **Planning Pregnancy** when? **Frequent Yeast Infection** Yes No
Birth Control *None* No-Sex Menopause Uterus-Removed Tubes-Tied Patch IUD Husband-Fixed Condom or **Pill-Brand name** for Years

Drug Allergies *None* Penicillin Tetracycline Sulfa Erythromycin Cephalosporin Doxycycline Minocycline Epinephrine Cortisone Antihistamines Anesthetics Codeine Topical medications &/or others Please list generic &/or brand names of all products:

Medications *None* Psych/Neuro Heart Circulation Blood Pressure Seizure Diabetes Pain Infections Arthritis Allergy HRT Steroids Weight Loss Drugs Prescriptions Non-Prescriptions Over-the-Counter Home Remedies Street Drugs Narcotics Alcohol Tobacco &/or Others Please write down generic &/or brand names of all products or provide a list.

Any other comments: *None* or Please list:

Dermatology
Review of Systems History Form

Please circle &/or describe.
Circle the word "None" if nothing applies

Name.....**Date**.....

Skin: Acne Spot Mole Wart Growth Rash Itching &/or other
Please describe ➔

General: Itching Pain Exhaustion Fatigue Malaise Weight Gain/Loss Headache Fever *None* &/or other
Please describe ➔

Allergic/Immunologic: Urticaria Hay fever Hives Persistent infections Hepatitis B C TB HIV *None* &/or other
Please describe ➔

Eyes: Swelling Eyelids Heliotrope Irritation Redness Vision loss Pain Glaucoma *None* &/or other
Please describe ➔

ENT: Pain Swelling Hearing Loss Nosebleeds Sore throat Hoarseness Dysphagia *None* &/or other
Please describe ➔

Cardiovascular: Chest pains Palpitations Syncope Leg Cramps Varicose Veins Peripheral edema *None* &/or other
Please describe ➔

Respiratory: Shortness of Breath Cough Blood in sputum wheezing Asthma *None* &/or other
Please describe ➔

Gastrointestinal: Nausea Ulcer Cramps Pain Bleeding Change in bowel habits *None* &/or other
Please describe ➔

Genitourinary: Enlarged prostate Urinary Problem Irregular Periods Abnormal Bleeding *None* &/or other
Please describe ➔

Musculoskeletal: Joint pain swelling Stiffness Arthritis Muscle weakness *None* &/or other
Please describe ➔

Neurologic: Stroke Weakness Abnormal sensation Pain Paresthesias Seizures Dizziness *None* &/or other
Please describe ➔

Psychiatric: Anxiety Fear Forgetfulness Depression Suicidal ideation *None* &/or other
Please describe ➔

Endocrine: Intolerance to Heat/Cold Excessive thirst/appetite/urination Weight Gain/Loss *None* &/or other
Please describe ➔

Heme/Lymphatic: Abnormal Bruising Bleeding Enlarged lymph nodes *None* &/or other
Please describe ➔

Any other comments: *None* or Please list ➔

Dermatology Exam & Management

Patient Name:

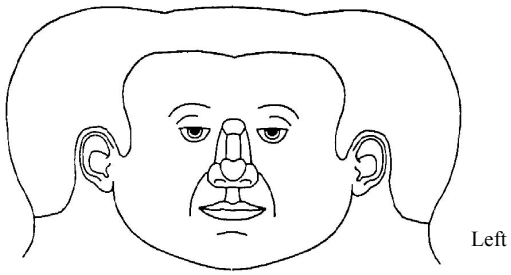
Date of Birth: **Age:**

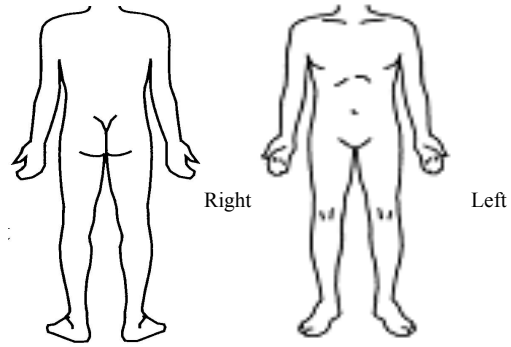
Date of Exam: **Sex:** M F

Chaperone/Scribe: Dr. Irum Pasha or List:
Drug Allergies & Contraindications: *None or List*

		Yes	No
Constitutional-General Appearance			
Build, Nutrition, Posture, Grooming	Normal		
Vital Signs Wt. Pulse, BP, Temp			
Neuro/Psychiatric		Yes	No
Alert & Oriented in T/S/P	Normal		
Mood and Affect	Normal		
Eyes		Yes	No
Eyelids and Conjunctivae	Normal		
Hair & Sweat Glands		Yes	No
Scalp & Body Hair	Normal		
Eccrine & Apocrine Glands	Normal		
Skin & Subcutaneous Tissues		Yes	No
Blemishes, Rashes, Lesions, Photodamage etc			
Head & Face	Normal		
Neck	Normal		
Chest, Breast & Axillae	Normal		
Abdomen	Normal		
Genitalia, Groin & Buttcks	Normal		
Back	Normal		
Right Upper Extremity	Normal		
Left Upper Extremity	Normal		
Right Lower Extremity	Normal		
Left Lower Extremity	Normal		
Cadiovascular (Peripheral)		Yes	No
No edema, Circulation ok	Normal		
Extremities		Yes	No
No digital cyanosis or clubbing	Normal		
Ear, Nose, Mouth & Throat		Yes	No
Lips, Teeth and Gums	Normal		
Oropharynx	Normal		
Neck		Yes	No
Thyroid, nodules or masses	Normal		
Lymph Nodes		Yes	No
1-Neck 2-Axillae 3-Groin	Normal		
Gastrointestinal		Yes	No
No anal growths or fissures	Normal		
No hepatosplenomegally	Normal		

Our Derm Exams are essentially Focused ie Spot Checks only.
Problem Based Exam:- Focused: 1 Expanded: 6 Detailed: 12





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