

TO SERVE YOU MORE EFFICIENTLY, PLEASE LIMIT ANSWERS TO CHECK MARKS ONLY UNLESS OTHERWISE NOTED. RETURN TO FRONT DESK. THANK YOU.

DATE: _____ ACCOUNT NUMBER: _____ AGE: _____ GENDER: M or F

PATIENT NAME: _____ DATE OF BIRTH: _____

PHARMACY NAME AND ZIP CODE: _____

PREFERRED LANGUAGE: ENGLISH _____ SPANISH _____ OTHER _____

RACE: WHITE _____ AMERICAN INDIAN/ALASKAN NATIVE _____ ASIAN _____
AFRICAN AMERICAN _____ NATIVE HAWAIIAN/PACIFIC ISLANDER _____ OTHER _____

ETHNICITY: HISPANIC/LATINO _____ NON-HISPANIC/LATINO _____ OTHER: _____

1) If you are here for a follow up, is the area we are treating:
Better _____ Worse _____ Unchanged _____

IF THIS VISIT IS FOR A FOLLOW-UP OR RECHECK OF AN EXISTING PROBLEM, PLEASE PROCEED TO QUESTION #9. IF YOU ARE HERE FOR A NEW PROBLEM, PROCEED TO QUESTION #2.

2) If this is a new problem, what symptoms are you currently experiencing?
Acne _____ Blister _____ Cyst _____ Growth _____ Hair loss _____ Infection _____ Itch _____
Lesion _____ Rash _____ Rough spot(s) _____ Sore _____ Ulcer _____ Wart _____ Other _____

3) Where is your new problem located? _____

4) How severe is the problem? Mild _____ Moderate _____ Severe _____

5) How long have you had this problem? _____

6) Do you have any of the following symptoms? Chills _____ Fever _____ Recent illness _____
Family member in the home with a similar rash _____

7) Are you currently treating this problem? Yes _____ No _____
If yes, what are you using? _____

8) If your new problem is a GROWTH, what best describes it?
Asymmetric (one side looks different from the other) _____ Bleeding _____ Changing color _____
Darkening _____ Growing _____ Irregular borders _____ Itchy _____ New _____ Painful _____
Scaly _____ Spreading _____

9) Do you have any medication changes since your last office visit? Yes _____ No _____

10) Have you had any surgeries or medication allergies since your last office visit? Yes _____ No _____

