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 ____