Colorado Mountain Medical
Doctors you know and trust.
A partner of Vail Health

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?

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 (l=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:

05.12.20