

Name _____ Date _____

Reason for visit (rash, lesion, mole, acne, itch, skin cancer, skin check, etc):

1. _____
2. _____
3. _____

Since your last visit:

New diagnosis: _____

New surgeries: _____

New medicines (do not fill out if you brought a medication list):

New drug allergy: _____

Change in smoking status: _____

PLEASE CIRCLE ANY THAT APPLY since your last visit:

- | | |
|--|---|
| anxiety (causing or from skin problem) | malaise |
| changing lesion | muscle weakness |
| depression (from skin problem) | nose bleeds |
| dry eyes | problems with bleeding |
| enlarged lymph nodes | problems with healing |
| fatigue | problems with scarring (thickened or keloids) |
| fever or chills | rash |
| hay fever | sleep problems (from skin problem) |
| headaches | sores in mouth |
| immunosuppressed | thyroid problems |
| joint aches | wheezing (with rash) |

ALERTS: PLEASE CIRCLE ANY THAT APPLY:

- | | |
|--------------------------------|-----------------------------------|
| heart valve replacement | pregnant / breast feeding |
| heart valve problem | organ transplant |
| defibrillator | premedication prior to procedures |
| lidocaine (Xylocaine) allergy | epinephrine allergy |
| blood thinners What type _____ | |
| latex allergy Describe _____ | |

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