Dermatology Specialists of St. Louis
Erin S. Gardner, MD FAAD FACMS

Patient: _____ **Age:** _____ **Date:** _____
Last First Middle

Select one: □ **This consultation was requested by Dr.** _____ **for** _____ □ **I was self-referred** □ **Existing patient**

Please fill out this form completely! Use* large *check marks.

WHAT BRINGS YOU HERE? □ Check Skin Spots/Moles/Lesion □ Rash □ Skin Cancer □ Other _____

1. What Location: □ **Whole body** □ **Other** _____

2. Duration of problem: ____ years / ____ months / ____ days OR □ Uncertain

3. Symptoms you are having: (Check those that apply.)

--If **Lesion or Skin Cancer**: □ **None** □ lesion growing □ non-healing □ bleeds □ changing color □ changing shape

--If **Rash**: □ **None** □ itching □ scaling □ crusting □ spreading □ tender □ painful

4. Previous / Current treatments (Lesion or Skin Cancer):

-For *this/these* lesion(s):

□ **None** □ Mohs surgery □ Excision □ Liquid nitrogen □ Curettage □ Blue Light / PDT □ Chemical peeling
Creams: □ 5-fluorouracil □ Imiquimod □ Other: _____

-For *other* lesion(s) you have had:

□ **None** □ Mohs surgery □ Excision □ Liquid nitrogen □ Curettage □ Blue Light / PDT □ Chemical peeling
Creams: □ 5-fluorouracil □ Imiquimod □ Other: _____

5. Previous / Current treatments (Rash): (check all that apply, *circle* any that *helped* the rash)

□ **None** □ Phototherapy □ Sun avoidance □ Discontinuation treatment:_____
Creams: □ Steroid cream □ Moisturizer □ Anesthetic □ Benadryl □ Anti-itch □ Antifungal □ other:_____
Oral medications: □ NSAIDs/Aspirin □ Benadryl □ Atarax □ Isotretinoin / Accutane □ Oral steroids □ other:_____

-Previous biopsy or laboratory results:_____

6. Quality/Feeling of your Rash:

□ burning □ stinging □ stabbing □ twinging □ puffy-feeling □ full-feeling □ tight-feeling □ progressive □ worsening

7. Timing/Context for your Rash: □ **NO particular factors influence my rash OR**
□ **The following factors have made my rash better or worse (select *only* those that apply):**

	better / worse			better / worse	
□ Day	□	□	□ Started after taking/using _____	□	□
□ Night	□	□	□ Before Meals	□	□
□ Morning	□	□	□ After Meals	□	□
□ Evening	□	□	□ Before Medications	□	□
□ With Sun Exposure	□	□	□ After Medications	□	□
□ Without Sun Exposure	□	□	□ During Exercise	□	□
□ Menstrual Period	□	□	□ After Exercise	□	□
□ Summer	□	□	□ After Make-Up Use	□	□
□ Winter	□	□	□ Following Trauma to the Site	□	□

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Medications you take: □ **None** □ List or attach list _____

_____

_____

Allergies to Medications: □ **None known** □ List:_____

Tell us about your Family History:

-*Family history* of **skin cancer:** □ **None** □ List type & relation: _____

-*Family history* of **other skin problems:** □ **None** □ List: _____

Tell us about your Social/Personal History:

Lifetime Occupational / Recreational Sun Exposure: □ light □ moderate □ heavy

Indoor Tanning: □ never □ occasional prior □ occasional current □ regular prior □ regular current

Living Situation: □ alone □ home with family / roommate □ assisted living

Alcohol Use: □ none □ social □ regular □ former
___drinks/day ___drinks/week ___drinks/month

Smoking: □ never □ current: ____ packs/day □ former

Tell us about your Skin/Dermatologic History: (check all that apply)

-History of **skin cancer:** □ **None** □ List type & site: _____

-History of **other skin diseases:** □ **None** □ List: _____

□ History of keloids □ History of poor wound healing

What other Dermatologic services or products interest you?

□ Moisturizers/emollients for sensitive skin □ Topical retinoids for fine wrinkling □ Botox
□ Sunscreens □ Chemical peels for fine wrinkling □ Hyaluronic fillers
□ Chemical peels for brown spots □ Light therapy for acne

► **Indicate below whether you have a history of any of the following conditions:**

Heart:	Yes	No
Pacemaker	□	□
Defibrillator	□	□
Artificial heart valve	□	□
Hypertension / high blood pressure	□	□
Heart disease	□	□
Coronary artery disease	□	□
Palpitations / irregular pulse	□	□
Heart murmurs	□	□
Heart failure / CHF	□	□
Cardiac malformation	□	□
Infective endocarditis	□	□
Blood clots	□	□
Heart transplant	□	□
Hematologic / Lymphatic:		
Anticoagulants / blood thinners	□	□
--specify: _____		
Bleeding disorder	□	□
Anemia	□	□
Swollen lymph nodes	□	□
Stem cell transplant	□	□
Musculoskeletal:		
Metal implants / artificial joints	□	□
Connective tissue disease	□	□
Lupus	□	□
Dermatomyositis	□	□
Mixed connective tissue disease	□	□
Sjogren's Syndrome	□	□
Arthritis – osteoarthritis	□	□
Arthritis – rheumatoid arthritis	□	□
Arthritis – psoriatic arthritis	□	□
Allergic / Immunologic:		
Antibiotics before dental work	□	□
Immune deficiency	□	□
-- specify: □ HIV		
□ transplant-associated		
□ other: _____		
Lungs:		
Asthma	□	□
Emphysema / COPD	□	□
Lung Transplant	□	□
Gastrointestinal:		
Ulcerative colitis / IBD	□	□
Crohn's / IBD	□	□
Hepatitis – viral	□	□
--specify: □ A □ B □ C □ D □ E		
Hepatitis – drug-induced	□	□
--specify drug: _____		
Cirrhosis	□	□
Liver transplant	□	□
Psychiatric:		
Psychosis	□	□
Mania	□	□
Dementia	□	□
Ear/Nose/Throat/Mouth:		
Herpes / cold sores	□	□

Neurologic:	Yes	No
Neurologic implant / stimulators	□	□
Fainting / syncope	□	□
Stroke / CVA	□	□
Hemorrhage / hematoma	□	□
Paralysis / weakness	□	□
Seizures / convulsions	□	□
Eyes:		
Inflammatory conditions	□	□
Glaucoma	□	□
Endocrine:		
Diabetes mellitus	□	□
Thyroid disease – hyperthyroidism	□	□
Thyroid disease – hypothyroidism	□	□
Thyroid disease – goiter/other	□	□
Other endocrine gland disease	□	□
--specify: □ pituitary □ adrenal		
□ pancreas □ parathyroid		
□ other: _____		
Infections History:		
Lyme disease	□	□
Syphilis	□	□
Mononucleosis	□	□
Epstein-Barr virus	□	□
Malaria	□	□
Tropical diseases	□	□
--specify: _____		
Oncologic:		
Non-skin cancers (if yes, specify)	□	□
□ Bone: _____		
□ Brain		
□ Breast		
□ Cervical		
□ Colon		
□ Esophageal		
□ Gastric / Stomach		
□ Kidney		
□ Leukemia		
□ Lung		
□ Lymphoma		
□ Prostate		
□ Testicular		
□ Uterine		
Genitourinary:		
Dialysis	□	□
Kidney transplant	□	□
Gynecologic		
Pregnant currently	□	□
Pregnant recently	□	□
--date: _____		
Period problems	□	□
Sexually transmitted disease	□	□
--specify: _____		
Genital lesions / masses	□	□
Contraception use	□	□
--specify: □ barrier □ hormonal		
□ non-hormonal IUD		
Sterilization – tubal ligation/vasectomy	□	□

Any other significant diseases / conditions: _____

Any other relevant surgical procedures: _____

_____

Patient/Guardian Signature Date