assuredimaging
Skin Cancer Screenings

SKIN CANCER SCREENING: PATIENT HISTORY FORM

Last Name	First Name	MI	DOB	Age	Sex
					☐ F ☐ M

Doctor	Doctor Address	Doctor Phone

Chief Complaint(s):

History of Present Illness:

Do you regularly visit tanning beds? ☐ YES ☐ NO

Do you work outdoors? ☐ YES ☐ NO

Family History of Skin Cancer: ☐ Mother ☐ Father ☐ Siblings ☐ Unknown ☐ None

Tobacco History: ☐ Current User ☐ Former User ☐ Never User

Patient Skin Type:

☐ Always burns, never tans, extremely sun sensitive ☐ Burns easily, tans a little, very sun sensitive ☐ Sometimes burns, then tans slowly, sun sensitive ☐ Burns a little, always tans ☐ Rarely burns, tans easily ☐ Never burns, deeply colored

Patient Medical History: *Please check all that apply:*

☐ No History of Skin Cancer	☐ History of Skin Cancer, Basal Cell	☐ History of Skin Cancer, Squamous Cell	☐ History of Skin Cancer, Unknown Type
☐ Melanoma	☐ Chronic Acne	☐ Eczema / Dermatitis	☐ Psoriasis
☐ History of Specific Skin Disease	☐ Problems with healing	☐ Develop keliods	☐ Cold Sores / Herpes
☐ Tape – skin allergy	☐ Shingles	☐ Hay Fever	☐ Hives
☐ HIV / AIDS	☐ Gluten Sensitivity	☐ Immune Suppression	☐ Anemia

Patient Signature: _____ Date: _____

EVALUATION AND MANAGEMENT (CONSULTATION TIME)			
☐ **New** patient office or other outpatient visits **(10 min.)**	99201	☐ **Established** patient office or other outpatient visits **(5 min.)**	99211
☐ **New** patient office or other outpatient visits **(20 min.)**	99202	☐ **Established** patient office or other outpatient visits **(10 min.)**	99212
☐ **New** patient office or other outpatient visits **(30 min.)**	99203	☐ **Established** patient office or other outpatient visits **(15 min.)**	99213

Clinician (PRINTED NAME)_____ Signature: _____ Date: _____