

Patient Name \_\_\_\_\_

Please answer the questions by **COMPLETELY FILLING IN** the correct bubble.  
Thank you!

**History of Present Illness (Prior to biopsy, if applicable)**

- |   |                           |                          |
|---|---------------------------|--------------------------|
| Has the lesion/area changed in size?                | <input type="radio"/> Yes | <input type="radio"/> No |
| Has the lesion/area changed in color?               | <input type="radio"/> Yes | <input type="radio"/> No |
| Has the lesion/area changed in elevation?           | <input type="radio"/> Yes | <input type="radio"/> No |
| Has the lesion/area changed in hardness?            | <input type="radio"/> Yes | <input type="radio"/> No |
| Has the lesion/area been bleeding?                  | <input type="radio"/> Yes | <input type="radio"/> No |
| Has the lesion/area been tingling?                  | <input type="radio"/> Yes | <input type="radio"/> No |
| Is the lesion/area painful?                         | <input type="radio"/> Yes | <input type="radio"/> No |
| Is the lesion/area itching?                         | <input type="radio"/> Yes | <input type="radio"/> No |
| Does the lesion/area have constant symptoms?        | <input type="radio"/> Yes | <input type="radio"/> No |
| Does the lesion/area only have occasional symptoms? | <input type="radio"/> Yes | <input type="radio"/> No |
| Was a biopsy done?                                  | <input type="radio"/> Yes | <input type="radio"/> No |
| Was there any treatment done other than biopsy?     | <input type="radio"/> Yes | <input type="radio"/> No |

**Dermatology Review of Systems**

- |                   |                           |                          |
|-------------------|---------------------------|--------------------------|
| Poor healing      | <input type="radio"/> Yes | <input type="radio"/> No |
| Abnormal scarring | <input type="radio"/> Yes | <input type="radio"/> No |

**Hematology Review of Systems**

- |                      |                           |                          |
|----------------------|---------------------------|--------------------------|
| Blood transfusions   | <input type="radio"/> Yes | <input type="radio"/> No |
| Bleeding problems    | <input type="radio"/> Yes | <input type="radio"/> No |
| Enlarged lymph nodes | <input type="radio"/> Yes | <input type="radio"/> No |

**Constitutional Review of Systems**

- |             |                           |                          |
|-------------|---------------------------|--------------------------|
| Weight loss | <input type="radio"/> Yes | <input type="radio"/> No |
| Fever       | <input type="radio"/> Yes | <input type="radio"/> No |

**ENT**

- |                 |                           |                          |
|-----------------|---------------------------|--------------------------|
| Glaucoma        | <input type="radio"/> Yes | <input type="radio"/> No |
| Hearing Aid     | <input type="radio"/> Yes | <input type="radio"/> No |
| Plastic surgery | <input type="radio"/> Yes | <input type="radio"/> No |

**Cardiology**

- |                                    |                           |                          |
|------------------------------------|---------------------------|--------------------------|
| Chest pain/Angina                  | <input type="radio"/> Yes | <input type="radio"/> No |
| Artificial or abnormal heart valve | <input type="radio"/> Yes | <input type="radio"/> No |
| Pacemaker or Defibrillator         | <input type="radio"/> Yes | <input type="radio"/> No |
| High blood pressure                | <input type="radio"/> Yes | <input type="radio"/> No |

**Respiratory**

- |                   |                           |                          |
|-------------------|---------------------------|--------------------------|
| Asthma            | <input type="radio"/> Yes | <input type="radio"/> No |
| Emphysema or COPD | <input type="radio"/> Yes | <input type="radio"/> No |

**Gastroenterology**

Gastrointestinal cancer history  Yes  No  
Colitis  Yes  No

**Musculoskeletal**

Arthritis  Yes  No  
Artificial joints  Yes  No

**Neurology**

Stroke  Yes  No  
Seizures  Yes  No

**Psychology**

Depression  Yes  No  
Anxiety  Yes  No

**Endocrinology**

Thyroid disorder  Yes  No

**Infectious Diseases**

Hepatitis  Yes  No  
HIV/AIDS  Yes  No  
Tuberculosis  Yes  No

**Past Medical History**

History of UV or X-Ray Treatments  Yes  No  
History of arsenic exposure  Yes  No  
History of Immunosuppression  Yes  No  
Organ Transplant recipient  Yes  No  
History of Basal Cell Carcinoma  Yes  No  
History of Squamous Cell Carcinoma  Yes  No  
History of Melanoma  Yes  No

Family History of Melanoma  Yes  No  
Family History of Basal Cell Carcinoma  Yes  No  
Family History of Squamous Cell Carcinoma  Yes  No