Pediatric Dermatology Evaluation Form

Today's Date: _____ **Intake Coordinator Initials:** _____

Referring M.D.: _____

PATIENT INFORMATION

Patient Name: _____ **Patient Sex:** ☐ Female ☐ Male

UC Davis Health MRN: _____ **Patient Age:** _____

REASON FOR DERMATOLOGY REFERRAL *(e.g., bumps, spots, sores, rashes)*

A. Patient's Main Concern *(describe concern)*:

Location on body:_____
How long present (days, months, years): _____
Symptoms (itching, burning, bleeding, pain, tenderness):_____
Indicate if symptoms are (constant, intermittent, worsening, improving, stable, etc.):
_____
Current treatment (creams, ointments, systemic): _____
Past treatment (creams, ointments, systemic): _____
How long has treatment been used (days, months, years): _____

B. Patient's Other Concern *(if applicable)*:

Location on body:_____
How long present (days, months, years): _____
Symptoms (itching, burning, bleeding, pain, tenderness):_____
Indicate if symptoms are (constant, intermittent, worsening, improving, stable, etc.):
_____
Current treatment (creams, ointments, systemic): _____
Past treatment (creams, ointments, systemic): _____
How long has treatment been used (days, months, years): _____

C. Acne: If the patient's concerns include acne, the provider must ***also*** photograph the upper chest and upper back, and address these additional questions:

1. **Has the patient started menstruation?** ☐ Yes ☐ No ☐ Not Applicable
2. **Is the photo taken during the exam representative of a good day, medium day or bad day for the patient's acne?** ☐ Good Day ☐ Medium Day ☐ Bad Day

D. Additional Comments: *(if applicable)*

BODY DIAGRAM

On the provided body diagram (located on a separate sheet of paper) please indicate using arrows or dots, the location(s) of the skin problem(s). *Diagram to be included with consent form.*

MEDICATIONS

A. Drug Allergies: ☐ Yes ☐ No Known Drug Allergies
If yes, list medications patient is allergic to and what type of reaction they had to that medication (e.g., rash, swelling, anaphylaxis, nausea/vomiting).

B. Skin Medications: *List all medicines for the patient's skin, including both oral and topical medications. Include medication name, dosage, concentration, type (e.g., cream, pill, ointment, etc.) and how long the medications have been used.*

C. Other Oral Medications: *List all oral medicines that are NOT for the patient's skin. Include name, dosage, how often it's taken and how long it has been used.*

D. Have any of the patient's medications changed recently? ☐ Yes ☐ No
If yes, please indicate which ones and explain the reasons.

PATIENT HISTORY

A. Does the patient have a personal history of skin cancer? ☐ Yes ☐ No
If yes, please specify: ☐ Squamous Cell Skin Cancer
☐ Basal Cell Skin Cancer
☐ Melanoma

B. Have the patient's parents or siblings ever been diagnosed with melanoma?
☐ Yes ☐ No *If yes, please list which family member*: _____

C. If the patient is an infant or toddler, any complications with his/her delivery or newborn course?

☐ Yes ☐ No *If yes, please explain:*

D. Please list ALL of the patient's physical and mental medical problems below *(e.g., high blood pressure, high cholesterol, HIV, heart problem, cancer history, depression, etc.).*

☐ No Known Medical Problems

E. Has the patient experienced any of the following in the past three months? Please check "Yes" or "No" for each section. Explain any "Yes" responses at the end of the questionnaire in the comments section.

☐ Check here if the patient experiences **NONE** of the following symptoms.

General Health: Significant weight loss or gain, fever, chills, or night sweats?	☐ Yes ☐ No
Skin/Hair/Nails: Rash anywhere else on the body, changes in hair growth or loss, or nail changes?	☐ Yes ☐ No
Eyes/Ears/Nose/Mouth/Throat: Headaches, lightheadedness, vision changes, ear pain, nose bleeds, colds, dental problems, neck pain or stiffness?	☐ Yes ☐ No
Cardiopulmonary: Chest pain, palpitations, shortness of breath, wheezing, cough, respiratory infections (including tuberculosis), edema in the legs, or pain in the legs upon walking?	☐ Yes ☐ No
Gastrointestinal: Abdominal pain, nausea, vomiting, constipation, or diarrhea?	☐ Yes ☐ No
Genitourinary: Urgency or frequency in urination, pain upon urinating, or change in urine color? For female patients, do you have irregular periods?	☐ Yes ☐ No
Musculoskeletal: Pain, swelling, redness or heat of muscles or joints, limitation of motion in any joints, or muscular weakness?	☐ Yes ☐ No
Neurologic/Psychiatric: Seizures, loss of sensation, difficulty with movements, difficulty with memory or speech, emotional problems, anxiety, depression, previous psychiatric care, or hallucinations?	☐ Yes ☐ No
Allergic/Immunologic/Lymphatic/Endocrine: Reactions to food or insect bites, bleeding tendency, swollen lymph nodes, intolerance to heat or cold?	☐ Yes ☐ No

F. Comments:

BODY DIAGRAM

Please indicate using arrows or dots, the location(s) of the skin problem(s).