Emory Dermatology Patient Intake (please fax to 404-712-4920)

Patient Name:_____

Email:_____

Phone (prefer cell phone):_____

Before we make an appointment:

It is our understanding that your skin condition has proved difficult to diagnose and/or manage. We believe it is part of our mission to address these types of challenges because certain patients may need and benefit from our specialized expertise. However, for us to do so effectively and to value your time, we believe it is essential for us to be prepared before you are even scheduled for your visit. Some patients have conditions for which we have no particular special expertise and it makes no sense for you to travel to see us. Other patients have disorders where we can make real impacts, but require that we prepare ahead of time. In either case, we need information from both you and from the physicians who are presently treating you.

If your skin problems do not fit this pattern, this clinic is not where you should be scheduled. You can be evaluated in treated in either our general dermatology practice or in one of our affiliated dermatology practices in the community.

Before you are seen:

Given our experience, we know that there is certain information that we will always need to better address whatever skin problem that you have. For reasons that I find baffling, we generally wait to ask these questions until after you have already arrived in the office. I find that I can be more effective if I know this information ahead of time. These questions are included in this questionnaire. You can provide these answers in a bulleted format or provide a written narrative which includes answers to these questions.

Once you are registered as a patient, it will take just a few minutes of your time. If you take the time to fill this out, We PROMISE we will review this before your visit. I want to begin to work for you even before you arrive at the clinic.

After you are seen:

We will copy your referring physician on our evaluation and coordinate your ongoing care with them. We will decide as to whether we can assume primary responsibility for your ongoing care after your initial evaluation.

1. Name and address of your primary care physician: _____

   _____

2. Name and address of your local dermatologist_____

   _____

3. Approximately how far do you live from Emory Clinic? _____ miles. How long does it take for you to travel here?

4. How many dermatologists have you seen for this problem previously?_____
   - What specific diagnoses do you recall have been applied to your condition

5. Have you seen other physicians for this condition and if so, which type and how many?
   - Allergist
   - Primary care physician
   - Other physician or health care professional

6. When did your skin condition begin? Month_____ Year_____

7. Where on your body did you first notice it?

8. What specific types of skin spots did you note initially?
   - Red areas
   - Bumps
   - Scaling
   - Blisters
   - Other? _____

9. Have you identified any specific triggers for your skin problem?Heat
   - Pressure
   - Stress
   - Sunlight
   - Foods
   - Things touching your skin
   - Other_____

10. What, if anything, have you found that relieves your skin problem? Does your skin problem respond to oral or injected steroids?

11. What treatments have you used (check all applicable)?
    - o Topical corticosteroids – if yes, which ones?
    - o Oral corticosteroids
    - o Injected corticosteroids
    - o Antibiotics
    - o Antihistamines
    - o Biologic therapies
    - o Light therapy
    - o Laser treatments
    - o Other drugs – please list on back if necessary

12. On average how much time do you spend dealing with your skin condition every day?
    _____ Minutes
    _____Hours

13. What tests have you had to evaluate your skin condition?
    - o Skin biopsy – if yes how many?
    - o Patch testing
    - o Scratch testing
    - o Blood tests
    - o Other tests _____

14. What concerns you **most** about your skin condition? – Please rank your concerns
    - o Skin symptoms?
    - o Skin appearance?
    - o Worry about associated issues such as other organ involvement or cancer?
    - o Other concerns or fears

15. What parts of your body are involved presently? Circle which apply...

o Scalp	o Abdomen	o Feet
o Face	o Back	o Nails
o Neck	o Buttocks	o Other
o Chest	o Genital/Groin	_____
o Arms	o Perianal	
o Hands	o Legs	

16. Do you have symptoms such as itch, pain, burning, stinging, or other symptoms now or within the past week? On a scale of 1-10 (1 being the mildest symptoms) how intense were your symptoms at their worst? Are they constant or intermittent?
17.

Least symptoms ---------- Most symptoms

Itch	0	1	2	3	4	5	6	7	8	9	10	Constant	Intermittent
Pain	0	1	2	3	4	5	6	7	8	9	10	Constant	Intermittent
Fatigue	0	1	2	3	4	5	6	7	8	9	10	Constant	Intermittent
Fever	0	1	2	3	4	5	6	7	8	9	10	Constant	Intermittent
Burn	0	1	2	3	4	5	6	7	8	9	10	Constant	Intermittent
Sting	0	1	2	3	4	5	6	7	8	9	10	Constant	Intermittent
Other	0	1	2	3	4	5	6	7	8	9	10	Specify _____	

18. Are there any other symptoms which concern you that you might believe are associated with your skin condition such as weight loss, loss of appetite? ___Yes___No If yes, what symptoms did you experience?

19. Were you ever hospitalized for your skin problem? ___Yes___No
20. Do you have a history of eczema, asthma, or seasonal allergies? ___Yes___No
21. Does anyone in your family have a history of eczema, asthma, or seasonal allergies? ___Yes___No
22. Does your skin condition affect your ability to function? (Check which apply)
    - o Sleep
    - o Work
    - o School
    - o Mood
    - o Social interactions
    - o Other _____
23. How best would you describe your current response to treatment?
    - o Much worse since treated
    - o Worse since treated
    - o No response
    - o Minimal response
    - o Partial response
    - o Near complete response
    - o Complete response
24. Is your current response to treatment adequate for your needs? ___Yes___No

25. What are your specific goals for this evaluation? What is the most important thing for me to accomplish:
    - At this visit:
    - Over the longer term:

26. What do you think is happening to your body and causing your problem (I really do want to know!)?

27. Other history or comments you might feel relevant to your care. Please feel free to write a detailed narrative on the back or on a separate sheet of paper. I really find this extremely useful.

28. Do you have computer access?
29. Do you regularly access the internet?
30. Have you ever taken an internet based computer survey?

Skin cancer risk profile

Do you have a personal history of skin cancer?

- Basal cell cancer – if yes estimate how many and most recent
- Squamous cell cancer - if yes estimate how many and most recent
- Melanoma - if yes estimate how many and most recent
- Other cancers or skin tumors _____

Sun Burn tendencies – (Circle one)

- Burn only/Tan after burning/Rarely burn/ Never burn

Do you have freckles?

What is your eye color?

What is your hair color?

Do you have a family history of skin cancer and if yes, which ones and in whom?

- Basal cell cancer
- Squamous cell cancer
- Melanoma
- Other

Do you have a family history of pancreatic cancer and if yes, in whom?

Do you currently use a tanning bed? ___Yes___No
If not, have you used one in the past? ___Yes___No

Do you use sunscreen? ___Yes___No
If yes how often? ____ Always _____ Always with significant sun exposure _____ Rarely

Do you wear a hat? ___Yes___No
If yes, how often? ____ Always _____ Always with significant sun exposure _____ Rarely

Do you wear sunglasses? ___Yes___No
If yes, how often? ____ Always _____ Always with significant sun exposure _____ Rarely

***Review of Systems - Are* you currently having, or have you had problems with:**

Circle all that apply, Strike through if negative

Please feel free to add other relevant symptoms

General well-being
Fever
Weight loss (>10 lbs)
Weight gain (> 10 lbs)
Fatigue
Night sweats

Eyes
Wear glasses
Wears Contact lenses
Glaucoma
Cataracts
Recent change in vision

Ears, Nose, Mouth and Throat
Hearing loss
Ringing in ears
Pain in ears
Balance disturbance
Nasal congestion
Nosebleeds
Sinus problems
Difficulty swallowing
Lip or mouth sores
Sore throats

Respiratory
Chronic cough
Bronchitis
Asthma
Shortness of breath
Wheezing

Cardiovascular
Chest pain
Irregular heartbeat
Arm and leg swelling

Gastrointestinal
Indigestion
Nausea
Vomiting
Abdominal pain
Change in bowel habits
Liver problems

Hematologic
Anemia
Easy bleeding / bruising
Swollen glands

Genitourinary
Painful urination
Blood in urine
Difficulty urinating
Incontinence
Kidney stones

Neurological
Fainting / blacking out
Seizures
Memory problems
Coordination problems
Uncontrolled shaking
Headache

Endocrine
Diabetes
Low blood sugar
Excessive thirst
Excessive urination
Heat intolerance
Cold intolerance
Abnormal periods

Immunologic
Environmental allergies
Hay fever
Food allergies
Immune system problems
Frequent colds / infections

Skin
Other Rashes
Changes in moles
New skin growths

Musculoskeletal
Arm or leg weakness
Joint pain or swelling
Back pain
Arthritis
Muscle weakness

Psychiatric
Anxiety
Depression
Manic/Depression
Schizophrenia
Panic attacks
Sleep difficulties

Other symptoms

General Medical History

Current Medications and drug allergies – you can include as a separate list. My nurse will ask you this again when you visit. We are working to automate this import process to get this information into the medical record.

Medical Illnesses: Feel free to create a separate summary of your conditions

- High blood pressure
- Diabetes
- Elevated blood lipids
- Heart disease
- Asthma
- Thyroid disease

Other _____

Hospitalizations and Surgical Procedures - Feel free to create a separate summary of your conditions

Family History

Family Member **Medical Illnesses**

Mother _____
Grandparents (maternal)_____
Father _____
Grandparents (paternal)_____
Sister(s) / Brother (s)_____
Family history of skin disease (for skin cancer see above)

- Eczema
- Psoriasis
- Autoimmune diseases _____
- Other _____

Social History

Are you presently working or going to school full or part time? __Yes __No
Employer / School: _____
What type of work do you do? _____
Marital Status:_____ Do you live alone? ____ Who lives with you?_____
Do you smoke? __Yes __No. Cigars?____Pipe?___Chewing tobacco?____
Cigarettes packs/per day?_____ How long have you been chewing or smoking?_____
Do you drink alcohol? __Yes __No.
If yes, do you drink daily and if so how much? _____
Prior or current other recreational drug use? _____
Caffeine intake: _____per day
Do you exercise? __ Yes __No
Type/Frequency:_____
Are you able to drive yourself to appointments? _____

THESE QUESTIONS CONCERN THE SKIN CONDITION WHICH HAS BOTHERED YOU THE MOST DURING THE PAST WEEK

During the past week, how often have you been bothered by:	Never Bothered ↓						Always Bothered ↓
	_____						
1. Your skin condition **itching**	☐0	☐1	☐2	☐3	☐4	☐5	☐6
2. Your skin condition **burning** or **stinging**	☐0	☐1	☐2	☐3	☐4	☐5	☐6
3. Your skin condition **hurting**	☐0	☐1	☐2	☐3	☐4	☐5	☐6
4. Your skin condition **being irritated** .	☐0	☐1	☐2	☐3	☐4	☐5	☐6
5. The **persistence / reoccurrence** of your skin condition	☐0	☐1	☐2	☐3	☐4	☐5	☐6
6. **Worry** about your skin condition (For example: that it will spread, get worse, scar, be unpredictable, etc)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
7. The **appearance** of your skin condition	☐0	☐1	☐2	☐3	☐4	☐5	☐6
8. **Frustration** about your skin condition.	☐0	☐1	☐2	☐3	☐4	☐5	☐6
9. **Embarrassment** about your skin condition	☐0	☐1	☐2	☐3	☐4	☐5	☐6
10. **Being annoyed** about your skin condition	☐0	☐1	☐2	☐3	☐4	☐5	☐6
11. **Feeling depressed** about your skin condition	☐0	☐1	☐2	☐3	☐4	☐5	☐6
12. The effects of your skin condition on your **interactions with others** .....(For example: interactions with family, friends, close relationships, etc)	☐0	☐1	☐2	☐3	☐4	☐5	☐6
13. The effects of your skin condition on your **desire to be with people**	☐0	☐1	☐2	☐3	☐4	☐5	☐6
14. Your skin condition making it hard to **show affection**	☐0	☐1	☐2	☐3	☐4	☐5	☐6
15. The effects of your skin condition on your **daily activities**	☐0	☐1	☐2	☐3	☐4	☐5	☐6
16. Your skin condition making it hard to **work or do what you enjoy**	☐0	☐1	☐2	☐3	☐4	☐5	☐6

Have you answered every item? Yes ☐ No ☐