

# Skin Lesion Clinic

Dr. Carley N. Cooper, MD CCFP (EM) Dip (SC)



Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Current Primary Care Provider: \_\_\_\_\_

Preferred name: \_\_\_\_\_

Email: \_\_\_\_\_

Preferred pronoun(s) (please circle): She/Her He/Him They/Them Other

Have you had skin cancer in the past?  Yes  No

Do you have family members with a history of skin cancer?  Yes  No

## PAST MEDICAL HISTORY (check any applicable boxes)

<input type="radio"/> Anemia <input type="radio"/> Anxiety <input type="radio"/> Autoimmune Disease: _____ <input type="radio"/> Bleeding/Clotting Disorder <input type="radio"/> Cancer: _____ <input type="radio"/> COPD/Emphysema <input type="radio"/> Connective Tissue Disorder <input type="radio"/> Dementia	<input type="radio"/> Diabetes mellitus <input type="radio"/> Type 1 <input type="radio"/> Type 2 By: <input type="radio"/> diet <input type="radio"/> medication <input type="radio"/> Depression <input type="radio"/> Edema/Swelling <input type="radio"/> Fibromyalgia/Chronic pain <input type="radio"/> Heart disease <input type="radio"/> Heart attack (myocardial infarction) When? _____	<input type="radio"/> Hepatitis B <input type="radio"/> Hepatitis C <input type="radio"/> High blood pressure (hypertension) <input type="radio"/> Low blood pressure (hypotension) <input type="radio"/> High cholesterol (hyperlipidemia) <input type="radio"/> HIV <input type="radio"/> Hypothyroidism <input type="radio"/> Hyperthyroidism	<input type="radio"/> Kidney Disease <input type="radio"/> Liver Disease <input type="radio"/> Lung Disease <input type="radio"/> MRSA infections <input type="radio"/> Sleep apnea <input type="radio"/> Stroke <input type="radio"/> Substance addiction <input type="radio"/> Transient ischemic attack (TIA) Other: _____ _____
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List any surgeries you have had: \_\_\_\_\_

## SUN PROTECTION STRATEGY

Circle all that apply:           None / Avoidance / Hat / Sunglasses / Protective Clothing / Sunscreen

## CURRENT MEDICATIONS (prescribed and over-the-counter)

\_\_\_\_\_  
\_\_\_\_\_

## CURRENT ALLERGIES

Circle all that apply:           None / Penicillin / Sulfa / Codeine / Erythromycin / LATEX / Adhesive / Tape

Other: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*By signing this form, you are acknowledging our zero harassment policy, and consent to the use of AI scribe and photo documentation