DERMATOLOGY

Skin examination

Blank documentation outlines. Adapt to the encounter and your practice requirements; complete only findings and care actually documented.

ENCOUNTER

Patient name:

Date of birth:

Date and time of encounter:

Clinician:

HISTORY

Patient concerns and changing lesions

Personal and family skin cancer history as reported

Relevant exposures and prior treatments

Medications and allergies reviewed

EXAMINATION

Extent of examination and areas deferred or declined

Chaperone discussion and presence if applicable

Findings by anatomic site and laterality

Lesion dimensions, morphology and dermoscopic findings if assessed

Photographs obtained and consent if applicable

ASSESSMENT AND PLAN

Problem or lesion, clinical impression and differential

Management options and decisions

Procedures actually performed or planned

Counseling provided

FOLLOW-UP

Follow-up timing and purpose

Return precautions discussed

Patient questions and understanding