USF Cutaneous Oncology Program
Skin Cancer Questionnaire

For Office Use Only

Patient ID Number

Date of visit: / /

Patient Information:

Last Name:

First Name: Initial:

Address:

Address (cont.) :

City:

State: Zip Code:

Phone: - -

Social Security Number: - -

Date of Birth: / / Age:

Sex: ○ Female ○ Male

Email Address:

Occupation:

State of Residence:

Country of Residence:

Marital status: ○ Married ○ Single ○ Widowed

What is your ethnic or racial background? (choose all that apply)

- ○ White, not Hispanic
- ○ White, Hispanic
- ○ Black, not Hispanic
- ○ Black, Hispanic
- ○ Chinese
- ○ Japanese
- ○ Filipino
- ○ Native American, Eskimo or Aleutian
- ○ Hawaiian
- ○ Korean
- ○ Vietnamese
- ○ Ashkenazi Jewish (European origin)
- ○ Don't know
- ○ Other

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History of present Illness:

1. How long has your lesion been present?	○ 0-6 months ○ 6-12 months	○ 1-2 years ○ longer	
2. Did your lesion change color?	○ No	○ Yes	○ Unknown
3. Did your lesion become larger?	○ No	○ Yes	○ Unknown
4. Did your lesion become smaller?	○ No	○ Yes	○ Unknown
5. Did your lesion change in shape?	○ No	○ Yes	○ Unknown
6. Did your lesion change in elevation above the skin?	○ No	○ Yes	○ Unknown
7. Did your lesion ever become scaly or crusty?	○ No	○ Yes	○ Unknown
8. Did your lesion ever open or ulcerate?	○ No	○ Yes	○ Unknown
9. Did your lesion ever bleed?	○ No	○ Yes	○ Unknown
11. Did your lesion ever become tender or painful?	○ No	○ Yes	○ Unknown
12. Did your lesion ever become soft or pliable?	○ No	○ Yes	○ Unknown
13. Did your lesion grow hair or have hair present?	○ No	○ Yes	○ Unknown
14. Did your lesion begin as a mole?	○ No	○ Yes	○ Unknown
15. Did your ever traumatize the "mole"?	○ No	○ Yes	○ Unknown
16. Did you have a large number of moles in childhood or at this time?	○ No	○ Yes	○ Unknown
17. Do you have moles present from birth?	○ No	○ Yes	○ Unknown
18. Do you have light colored eyes (blue, green or grey)?	○ No	○ Yes	○ Unknown
19. Do you have Xeroderma Pigmentosa?	○ No	○ Yes	○ Unknown
20. Do you work indoors?	○ No	○ Yes	○ Unknown
21. Do you work outdoors?	○ No	○ Yes	○ Unknown
22. Do you persue outdoor recreational activities?	○ No	○ Yes	○ Unknown
23. Do you sunburn easily?	○ No	○ Yes	○ Unknown
24. Do you freckle?	○ No	○ Yes	○ Unknown
25. Do you use sunscreen?	○ No	○ Yes	○ Unknown

If yes, for how many years? ☐☐.☐

If yes, what strength (SPF)? ☐☐☐

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History of present Illness (cont.):

26. Have you ever had blistering sunburns? ○ No ○ Yes ○ Unknown
27. Have you ever used sunlamps? ○ No ○ Yes ○ Unknown
28. Have you ever had tanning treatments? ○ No ○ Yes ○ Unknown
29. Have you been treated for psoriasis? ○ No ○ Yes ○ Unknown

    If yes, what kind of treatment?

30. Have you ever had vitiligo (loss of skin color)? ○ No ○ Yes ○ Unknown
31. Have you ever had white rings around any mole or birthmark? ○ No ○ Yes ○ Unknown
32. Have you ever had a birthmark or mole disappear on it's own? ○ No ○ Yes ○ Unknown
33. Have you ever had a birthmark removed? ○ No ○ Yes ○ Unknown

    If yes, why was it removed?

34. Have you ever been exposed to radioactive chemicals? ○ No ○ Yes ○ Unknown
35. Have you ever been exposed to toxic (poisonous) chemicals? ○ No ○ Yes ○ Unknown
36. Do you perform skin self-exams? ○ No ○ Yes ○ Unknown
37. Have you ever had a blood transfusion? ○ No ○ Yes ○ Unknown
38. Do you smoke? ○ No ○ Yes ○ Unknown

    If yes, how much (packs per day)? .

    If yes, how long have you smoked (number of years)? .

39. Did you quit smoking? ○ No ○ Yes ○ Unknown

    If yes, what year did you quit?

    If yes, how much did you smoke (packs per day)? .

40. What percentage of your working hours do you spend outdoors? .

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Past Medical History:

1. Please list any medications you are now taking, including vitamins and non-prescription drugs. If there are more than 8, please attach a seperate sheet listing the other medications.

Medication	Dose (please include units)

2. List any allergies and describe the reaction.

Allergy	
	○ Rash or hives ○ Nausea, vomitting or diarrhea ○ Light headed, low blood pressure, throat closed
	○ Rash or hives ○ Nausea, vomitting or diarrhea ○ Light headed, low blood pressure, throat closed
	○ Rash or hives ○ Nausea, vomitting or diarrhea ○ Light headed, low blood pressure, throat closed
	○ Rash or hives ○ Nausea, vomitting or diarrhea ○ Light headed, low blood pressure, throat closed
	○ Rash or hives ○ Nausea, vomitting or diarrhea ○ Light headed, low blood pressure, throat closed

3. List any other significant medical problems.

Problem	Date of Diagnosis	Status
	/ /	○ Active ○ Inactive
	/ /	○ Active ○ Inactive
	/ /	○ Active ○ Inactive
	/ /	○ Active ○ Inactive
	/ /	○ Active ○ Inactive

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Past Medical History, for Women Only:

1. What type of hormones have you used?
   ○ None ○ Oral contraceptives ○ Menopausal estrogens
2. If you did use hormones, how many years did you take them? ☐☐.☐
3. Have you ever been pregnant? ○ No ○ Yes ○ Unknown
   If Yes, how many live births? ☐☐
   If Yes, how many abortions/miscarriages? ☐☐
4. Were you pregnant when diagnosed with Melanoma? ○ No ○ Yes ○ Unknown
   If Yes, what is the date of birth of your child? ☐☐ / ☐☐ / ☐☐☐☐
5. Did you become pregnant after you were diagnosed with Melanoma or during your treatment? ○ No ○ Yes ○ Unknown
   If Yes, what is the date of birth of your child? ☐☐ / ☐☐ / ☐☐☐☐
6. Are you pregnant now? ○ No ○ Yes ○ Unknown
7. Have you recently had a mammogram? ○ No ○ Yes ○ Unknown
   If Yes, what was the date of your mammogram? ☐☐ / ☐☐ / ☐☐☐☐
8. Do you have tender breasts? ○ No ○ Yes ○ Unknown
9. Do you have any nipple discharge? ○ No ○ Yes ○ Unknown
10. Any lumps or changes in breast size? ○ No ○ Yes ○ Unknown
11. Do you have fibrocystic disease? ○ No ○ Yes ○ Unknown
12. Have you breast fed children? ○ No ○ Yes ○ Unknown
13. Do you have menstrual problems? ○ No ○ Yes ○ Unknown

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Past Surgeries, Injuries, Hospitalizations: (use a separate sheet if needed)

1. Date (mm/dd/yyyy) ___ / ___ / ____ Type of surgery, injury or hospitalization
   Age at time of surgery ___ Facility
2. Date (mm/dd/yyyy) ___ / ___ / ____ Type of surgery, injury or hospitalization
   Age at time of surgery ___ Facility
3. Date (mm/dd/yyyy) ___ / ___ / ____ Type of surgery, injury or hospitalization
   Age at time of surgery ___ Facility
4. Date (mm/dd/yyyy) ___ / ___ / ____ Type of surgery, injury or hospitalization
   Age at time of surgery ___ Facility
5. Date (mm/dd/yyyy) ___ / ___ / ____ Type of surgery, injury or hospitalization
   Age at time of surgery ___ Facility

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Review of Systems: (Please check all of the following that apply to your current health)

General:
- ○ Fever
- ○ Chills
- ○ Poor appetite
- ○ Sleep poorly
- ○ Unusual fatigue

Skin:
- ○ Chronic or recurring skin condition
- ○ Lump or growth on skin
- ○ Change in skin color

Eyes:
- ○ Glasses
- ○ Change in vision
- ○ Pain in eyes
- ○ Glaucoma

Ears:
- ○ Difficulty hearing
- ○ Deafness
- ○ Earaches
- ○ Discharge from ears
- ○ Buzzing or ringing in ears

Nose and throat:
- ○ Frequent sneezing
- ○ Nose continually stuffed or runny
- ○ Nose bleeds
- ○ Recurrent sore throats
- ○ Persistent hoarseness
- ○ Dental problems
- ○ Sinus problems
- ○ Enlarged lymph nodes (swollen glands)
- ○ Mouth ulcers
- ○ Difficulty swallowing

Cardiopulmonary:
- ○ Chest pain
- ○ Heart murmurs
- ○ Shortness of breath
- ○ Cough
- ○ Blood in sputum
- ○ Asthma
- ○ Wheezing
- ○ Irregular heartbeat
- ○ Swelling of legs
- ○ History of blood clots
- ○ Use of oxygen
- ○ Hypertension
- ○ Hypotension

Gastrointestinal:
- ○ Frequent heartburn or indigestion
- ○ Nausea or vomitting
- ○ Stomach pain
- ○ Diarrhea
- ○ Blood in stool
- ○ Trouble swallowing
- ○ Ulcers
- ○ Jaundice
- ○ Constipation

Genitourinary:
- ○ Painful urination
- ○ Frequent urination
- ○ Blood in urine
- ○ Discharge (penile or vaginal)
- ○ Vaginal ulcers

Lymphatic
- ○ Swollen glands
- ○ Lymphedema

Musculoskeletal:
- ○ Painful joints
- ○ Sore muscles
- ○ Back pain
- ○ Osteoporosis

Neuropsychiatric:
- ○ Forgetfullness (memory loss)
- ○ Frequent or severe headaches
- ○ Dizziness or faintness
- ○ Change in anxiety level
- ○ Numbness or tingling of hands or feet
- ○ Weakness of an arm or leg
- ○ Depression

Hematologic:
- ○ Easy bruising
- ○ Frequent nose bleeds
- ○ Frequent bleeding gums
- ○ Anemia

Endocrine:
- ○ Heat or cold intolerance
- ○ Dryness to skin and hair
- ○ Enlarged thyroid
- ○ Increased thirst

Menopausal
- ○ Symptomatic hot flashes
- ○ Symptomatic vaginal dryness
- ○ Difficulty sleeping
- ○ Mood swings

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Family History: (Please check all of the following that apply to your family history)

			If Yes, who in your family? (mother, father, sister, brother, etc.)
Tuberculosis	○ No	○ Yes	
Asthma	○ No	○ Yes	
Glaucoma	○ No	○ Yes	
High blood pressure	○ No	○ Yes	
Low blood pressure	○ No	○ Yes	
Diabetes	○ No	○ Yes	
Arthritis	○ No	○ Yes	
Heart disease	○ No	○ Yes	
Blood disorders	○ No	○ Yes	
Bleeding tendencies	○ No	○ Yes	
Large moles	○ No	○ Yes	
Dysplastic nevus syndrome	○ No	○ Yes	
Melanoma	○ No	○ Yes	
Other cancer	○ No	○ Yes	
	If yes, what type of cancer?		

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