1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME

DOB

AGE/SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

VISIT TYPE: DERMATOLOGY CONSULTATION / FOLLOW-UP / SKIN CHECK / RASH EVALUATION / LESION EVALUATION / PROCEDURE FOLLOW-UP / TELEHEALTH

CARE SETTING: OUTPATIENT / DERMATOLOGY CLINIC / PRIMARY CARE / TELEHEALTH

PRIMARY CARE PROVIDER, IF APPLICABLE

REFERRING PROVIDER, IF APPLICABLE

INTERPRETER USED, IF APPLICABLE

CHAPERONE PRESENT, IF APPLICABLE

CC CHIEF COMPLAINT

2 PRIMARY DERMATOLOGY CONCERN

Document the primary dermatology-related reason for the visit in the patient's own words when possible, including rash, acne, eczema, psoriasis, skin lesion, mole check, skin cancer screening, hair loss, nail concern, itching, infection, wound, pigmentation concern, medication reaction, biopsy follow-up, or treatment monitoring.

S SUBJECTIVE

3 PATIENT-REPORTED HISTORY

Document patient-reported skin, hair, nail, mucosal, systemic, medication, exposure, and treatment history.

3a PRESENTING CONCERN

Reason for Dermatology Evaluation:

Document whether the visit is for initial evaluation, follow-up, full-body skin examination, rash evaluation, acne follow-up, eczema/psoriasis management, lesion check, skin cancer screening, hair/nail concern, infection concern, medication reaction, biopsy review, or procedure follow-up.

History of Present Illness:

Document onset, duration, location, distribution, progression, severity, recurrence, associated symptoms, triggers, relieving factors, prior episodes, prior evaluation, treatment tried, response to treatment, and patient concerns.

Skin Lesion History:

Document location, duration, change in size/color/shape, bleeding, crusting, ulceration, itching, pain, trauma, prior biopsy, prior treatment, personal concern, and whether lesion is new or changing.

Rash History:

Document location, morphology if described, spread, symmetry, itching, pain, burning, drainage, scaling, blistering, crusting, swelling, fever, systemic symptoms, and pattern of flares/remissions.

Pruritus / Pain Symptoms:

Document severity, timing, nighttime symptoms, triggers, associated rash or skin changes, excoriations, sleep impact, functional impact, and prior antipruritic or pain treatments.

3b CONDITION-SPECIFIC HISTORY

Acne / Rosacea Symptoms, if applicable:

Document lesion type, distribution, severity, flares, menstrual association, triggers, scarring, hyperpigmentation, prior therapies, response, dryness/irritation, and psychosocial impact.

Eczema / Atopic Dermatitis History, if applicable:

Document affected areas, itch severity, flare frequency, sleep disruption, triggers, moisturization routine, topical steroid use, non-steroidal therapies, infection history, allergies, asthma, and family history of atopy.

Psoriasis History, if applicable:

Document affected areas, body surface area if known, joint pain/stiffness, nail changes, scalp/genital involvement, treatment history, systemic therapy/biologic use, infection history, and impact on function or quality of life.

Hair and Scalp Symptoms:

Document hair shedding, thinning, patchy loss, scalp itching, scaling, pain, breakage, traction practices, chemical treatments, postpartum status, stressors, nutrition, medications, and prior hair-loss treatment.

Nail Symptoms:

Document discoloration, thickening, brittleness, pitting, lifting, pain, drainage, trauma, occupational exposure, fungal history, psoriasis history, and treatment tried.

Mucosal / Genital Skin Symptoms, if applicable:

Document oral, lip, vulvar, penile, perianal, or other mucosal lesions; pain; itching; ulcers; discharge; bleeding; sexual health concerns; STI history; hygiene practices; and chaperone use when examined.

3c EXPOSURES & RISK

Sun Exposure and Skin Cancer Risk:

Document history of sunburns, tanning bed use, outdoor work, sunscreen use, protective clothing, immunosuppression, radiation exposure, personal or family history of melanoma or non-melanoma skin cancer, and prior biopsies.

Medication and Product Exposure History:

Document prescription medications, over-the-counter medications, supplements, recent new medications, topical products, cosmetics, hair products, fragrances, adhesives, occupational exposures, and possible allergens or irritants.

Infectious Exposure History:

Document sick contacts, travel, animal exposure, insect bites, hot tub exposure, gym/wrestling exposure, household contacts with rash, fungal exposure, STI exposure, and prior skin infections.

Autoimmune / Systemic Symptoms:

Document fever, weight loss, fatigue, joint pain, muscle weakness, photosensitivity, oral ulcers, Raynaud symptoms, sicca symptoms, GI symptoms, respiratory symptoms, or other systemic findings related to dermatologic disease.

3d TREATMENT & BACKGROUND

Treatment History and Response:

Document topical medications, oral medications, injections, biologics, phototherapy, procedures, wound care, moisturizers, sunscreen, antibiotics, antifungals, antivirals, adherence, side effects, and treatment barriers.

Past Dermatologic History:

Include prior skin cancers, dysplastic nevi, eczema, psoriasis, acne, rosacea, hidradenitis suppurativa, vitiligo, alopecia, urticaria, contact dermatitis, chronic wounds, keloids, or prior dermatologic procedures.

Family History:

Document family history of melanoma, non-melanoma skin cancer, psoriasis, eczema, autoimmune disease, alopecia, atopy, genetic skin disease, or keloid tendency.

Social / Occupational History:

Document occupation, sun exposure, chemical exposure, glove use, wet work, hobbies, sports, household exposures, pets, smoking/nicotine use, alcohol use, and barriers to skin care or medication access.

Pertinent Negatives:

Document denial of red-flag symptoms when clinically relevant, including rapidly changing lesion, non-healing ulcer, spontaneous bleeding lesion, painful expanding rash, fever, mucosal involvement, facial/lip/tongue swelling, skin sloughing, eye pain, severe medication reaction symptoms, or immunosuppression-related concerns.

ROS DERMATOLOGY REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Document pertinent positives and negatives:

Rash, itching, burning, pain, swelling, drainage, scaling, crusting, blistering, or ulceration

New, changing, bleeding, painful, or non-healing skin lesion

Acne, rosacea flares, scarring, hyperpigmentation, or treatment irritation

Hair loss, scalp scaling, scalp pain, nail changes, or mucosal lesions

Fever, fatigue, weight loss, night sweats, joint pain, photosensitivity, oral ulcers, or systemic symptoms

Medication reaction symptoms, hives, swelling, respiratory symptoms, or mucosal involvement

Sunburns, tanning exposure, skin cancer history, or immunosuppression-related concerns

Psychosocial distress, sleep disruption, pain, or functional impact related to skin disease

O OBJECTIVE

5 OBSERVED FINDINGS

Document observed dermatology-relevant findings and examination details.

5a VITALS, IF OBTAINED

TEMPERATURE	BLOOD PRESSURE	HEART RATE
RESPIRATORY RATE	OXYGEN SATURATION	HEIGHT
WEIGHT	BMI	PAIN SCORE, IF APPLICABLE

5b EXAMINATION

General Appearance:

Document alertness, distress level, comfort level, scratching, hygiene, overall appearance, and ability to participate in care.

Skin Examination:

Document distribution, morphology, color, size, number, configuration, scale, crust, vesicles, bullae, pustules, erosions, ulcers, plaques, papules, nodules, macules, patches, excoriations, lichenification, atrophy, scarring, hyperpigmentation, hypopigmentation, and signs of infection.

Lesion-Specific Examination:

Document lesion location, size, shape, border, color variation, symmetry, elevation, surface changes, tenderness, bleeding, ulceration, dermoscopic features if used, and comparison to prior photographs or measurements.

Full-Body Skin Examination, if performed:

Document areas examined, areas not examined or deferred, patient tolerance, chaperone use when applicable, benign lesions, suspicious lesions, actinic damage, nevi pattern, scars, and prior procedure sites.

Scalp / Hair:

Document hair density, pattern of loss, erythema, scale, pustules, scarring, broken hairs, traction signs, follicular openings, and pull test if performed.

Nails:

Document nail plate, nail bed, cuticle, periungual skin, pitting, onycholysis, thickening, discoloration, ridging, splinter hemorrhages, paronychia, or dystrophy.

Mucosa, if examined:

Document oral, lip, ocular, genital, or perianal mucosal findings, including ulcers, erosions, plaques, pigment changes, discharge, atrophy, tenderness, and exam limitations.

Lymph Nodes, if relevant:

Document cervical, axillary, epitrochlear, inguinal, or regional lymphadenopathy when skin cancer, infection, or systemic disease is a concern.

Musculoskeletal, if relevant:

Document joint swelling, tenderness, range of motion, dactylitis, enthesitis, or psoriatic arthritis-related findings when assessed.

MD DERMATOLOGIC MORPHOLOGY / DISTRIBUTION ASSESSMENT

6 MORPHOLOGY & PATTERN

Document lesion morphology and pattern using dermatologic terminology when applicable. Include:

PRIMARY LESION TYPE

SECONDARY SKIN CHANGES

DISTRIBUTION AND SYMMETRY

BODY SURFACE AREA AFFECTED WHEN RELEVANT

SEVERITY GRADING WHEN APPLICABLE

PRESENCE OF INFECTION, EXCORIATION, LICHENIFICATION, SCARRING, PIGMENT CHANGE, OR ULCERATION

DERMOSCOPIC FINDINGS WHEN PERFORMED

COMPARISON WITH PRIOR PHOTOGRAPHS OR MEASUREMENTS

FUNCTIONAL OR COSMETIC IMPACT

PR PROCEDURES PERFORMED, IF APPLICABLE

7 IN-OFFICE PROCEDURES

Document dermatologic procedures performed during the visit. Include procedure name, indication, consent, site verification, anesthesia if used, technique, specimen details, hemostasis, dressing, patient tolerance, complications, aftercare instructions, and pathology follow-up plan. Examples may include: Shave biopsy · Punch biopsy · Excisional biopsy · Cryotherapy · Intralesional injection · Incision and drainage · Curettage and electrodessication · Skin culture collection · KOH prep · Wart treatment · Comedone extraction · Suture removal · Wound care / dressing change · Phototherapy counseling or treatment documentation.

ST SCREENING / ASSESSMENT TOOLS

8 SCORES & INTERPRETATION

Document dermatology-specific tools used and interpretation, if applicable. Include: Body surface area estimate · Investigator Global Assessment · Eczema Area and Severity Index · Psoriasis Area and Severity Index · Dermatology Life Quality Index · Acne severity grading · Melanoma ABCDE assessment · Dermoscopy assessment · Pruritus numeric rating scale · Pain scale · PHQ-9 / GAD-7 when psychosocial impact is relevant · Medication adherence assessment. Include score, result, interpretation, comparison to prior results, and limitations.

L LABORATORY AND DIAGNOSTIC RESULTS

9 REVIEWED & ORDERED

Document dermatology-relevant results reviewed or ordered. Include:

Pathology:

Skin biopsy results, margin status, histologic diagnosis, immunostains, direct immunofluorescence, and pending pathology.

Microbiology:

Bacterial culture, fungal culture, viral PCR, HSV/VZV testing, wound culture, sensitivities, or KOH prep findings.

Laboratory Testing:

CBC, CMP, liver function, renal function, hepatitis/TB/HIV screening for systemic therapy, inflammatory markers, autoimmune labs, thyroid testing, ferritin, vitamin D, zinc, or medication monitoring labs when relevant.

Allergy / Contact Dermatitis Testing:

Patch testing, allergy testing, suspected allergens, relevance, and avoidance recommendations.

Imaging:

Ultrasound, MRI, CT, or other imaging for soft tissue infection, mass, lymph node, or systemic involvement when relevant.

Prior Records Reviewed:

Primary care notes, dermatology notes, oncology notes, rheumatology notes, allergy records, operative reports, pathology reports, culture results, medication history, prior photographs, and outside records.

A ASSESSMENT

10 DERMATOLOGIC CLINICAL INTERPRETATION

Provide dermatology-specific clinical interpretation: Primary dermatologic diagnosis or working diagnosis · Differential diagnoses considered · Lesion or rash morphology, distribution, and severity · Acute versus chronic status · Infectious, inflammatory, autoimmune, allergic, medication-related, neoplastic, environmental, occupational, or genetic contributors · Presence or absence of concerning features for malignancy, severe drug eruption, systemic disease, or infection · Treatment response, adherence, side effects, and barriers · Pathology, culture, lab, dermoscopy, or imaging correlation with clinical findings · Need for biopsy, culture, labs, medication adjustment, procedural treatment, systemic therapy, referral, skin cancer surveillance, or urgent escalation.

P PLAN

11 DERMATOLOGY MANAGEMENT BY PROBLEM

Outline dermatology management by problem. Include:

Topical treatment plan

including medication name, application site, frequency, duration, amount, steroid potency counseling, moisturizer/barrier care, and side effect precautions.

Systemic treatment plan

including oral medications, biologics, immunosuppressants, antibiotics, antifungals, antivirals, antihistamines, monitoring labs, contraindications, and safety counseling.

Procedure plan

including biopsy, cryotherapy, excision, injection, culture, wound care, pathology follow-up, aftercare, and return precautions.

Skin cancer prevention plan

including sunscreen, protective clothing, avoidance of tanning beds, self-skin exams, ABCDE education, photo monitoring, and recommended surveillance interval.

Rash or dermatitis plan

including trigger avoidance, gentle skin care, fragrance-free products, patch testing when indicated, occupational protection, and flare plan.

Acne/rosacea plan

including topical regimen, oral therapy, hormonal therapy when appropriate, trigger counseling, irritation management, pregnancy precautions, and scarring prevention.

Psoriasis/eczema plan

including severity-based therapy, maintenance plan, flare management, infection precautions, systemic therapy discussion, joint symptom screening, and specialty coordination when indicated.

Hair/nail plan

including diagnostic testing, topical/oral therapy, scalp care, nail care, fungal testing, nutrition evaluation, and follow-up monitoring.

Infection plan

including culture, antimicrobial selection, hygiene measures, household precautions, decolonization when appropriate, and warning signs.

Medication monitoring plan

including labs, pregnancy precautions, contraception counseling when relevant, immunization considerations, infection risk counseling, and follow-up schedule.

Referral and care coordination plan

with dermatologic surgery, Mohs surgery, dermatopathology, rheumatology, allergy/immunology, oncology, infectious disease, wound care, primary care, or emergency care when indicated.

Patient education

regarding diagnosis, expected course, medication use, skin care routine, sun protection, procedure aftercare, red flags, and when to seek urgent or emergency care.

F FOLLOW-UP

12 REASSESSMENT PLAN

Specify follow-up timeframe and purpose, including treatment response, rash reassessment, lesion monitoring, biopsy/pathology review, suture removal, medication monitoring, full-body skin examination, procedure follow-up, or urgent return precautions.

TB TIME DOCUMENTATION & BILLING

13 TIME DOCUMENTATION (IF APPLICABLE)

TOTAL TIME SPENT

COUNSELING / EDUCATION TIME

PROCEDURE TIME, IF APPLICABLE

SKIN CANCER COUNSELING TIME, IF APPLICABLE

MEDICATION MONITORING TIME, IF APPLICABLE

CARE COORDINATION TIME

RECORDS REVIEW TIME, IF APPLICABLE

13a BILLING CONSIDERATIONS — E/M / DERMATOLOGY CODING

E/M LEVEL: [E.G., 99202 / 99203 / 99204 / 99205 / 99212 / 99213 / 99214 / 99215]

BIOPSY CODE(S), IF APPLICABLE

DESTRUCTION / CRYOTHERAPY CODE(S), IF APPLICABLE

INJECTION CODE(S), IF APPLICABLE

EXCISION / REPAIR CODE(S), IF APPLICABLE

PATHOLOGY / TEST INTERPRETATION CODE(S), IF APPLICABLE

BASIS FOR BILLING: [TIME-BASED / MEDICAL DECISION MAKING / PROCEDURE-BASED / PREVENTIVE SKIN SCREENING / TEST INTERPRETATION]

ICD-10 DIAGNOSIS CODES: [PRIMARY DERMATOLOGIC DIAGNOSIS CODE + DESCRIPTION]

[SECONDARY DIAGNOSIS / LESION / SYMPTOM CODE(S), IF APPLICABLE]

SO SIGNATURE

14 PROVIDER SIGN-OFF

PROVIDER NAME

CREDENTIALS

SPECIALTY: DERMATOLOGY

DATE

TIME