

*In line with CMS's E/M documentation simplification, the AAD has developed the following Ancillary Staff Checklist tools to assist your clinical staff in taking a patient's history based on the new CMS guidance. This tool is to help ease and streamline medical record documentation while capturing relevant clinical details regarding the HPI or ROS portion of the E/M. To meet this end AAD staff and fellow members have incorporated a list of questions in the tool that a dermatologist might expect the ancillary staff to ask a patient at the initial encounter for each of the nine specific symptom or condition included in the tool. While this tool may be used in its current paper format, the format is also conformable to the practice's electronic health record.*

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### **CHIEF COMPLAINT: PSORIASIS**

Review and document the following medical interview question relevant to the chief complaint for each of the outlined history elements:

#### **Where is the plaque(s) located?**

Head      Face      Neck      Chest      Abdomen      Back      Genitalia      Shoulder (Rt/Lt)  
Upper Arm (Rt/Lt)      Forearm (Rt/Lt)      Hand (Rt/Lt)      Hip/Buttocks (Rt/Lt)      Thigh (Rt/Lt)  
Lower Leg (Rt/Lt)      Foot (Rt/Lt)

#### **How long has it been present?**

\_\_\_\_\_ Days    \_\_\_\_\_ Weeks    \_\_\_\_\_ Month    \_\_\_\_\_ Years

Are there other signs/symptoms present?      Yes / No

If so, what are they? \_\_\_\_\_

Are the symptoms present daily?      Yes / No

# Practice Management Center

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## Ancillary Documentation Checklists

On a scale of 1-10 how bad is the flare?

(1 - not bad and 10 - extremely bad)

1 2 3 4 5 6 7 8 9 10

Does anything make it better? Yes / No

If so, what? \_\_\_\_\_

Does anything make it worse? Yes / No

If so, what? \_\_\_\_\_

### FOLLOW-UP

Is the condition improving? Yes / No

If no, address the following questions:

Where are the new areas located?

Head      Face      Neck      Chest      Abdomen      Back      Genitalia      Shoulder (Rt/Lt)  
Upper Arm (Rt/Lt)      Forearm (Rt/Lt)      Hand (Rt/Lt)      Hip/Buttocks (Rt/Lt)      Thigh (Rt/Lt)  
Lower Leg (Rt/Lt)      Foot (Rt/Lt)

Are other signs/symptoms present? Yes / No

If so, what are they? \_\_\_\_\_

Are symptoms present daily? Yes / No

On a scale of 1-10 how bad is the flare?

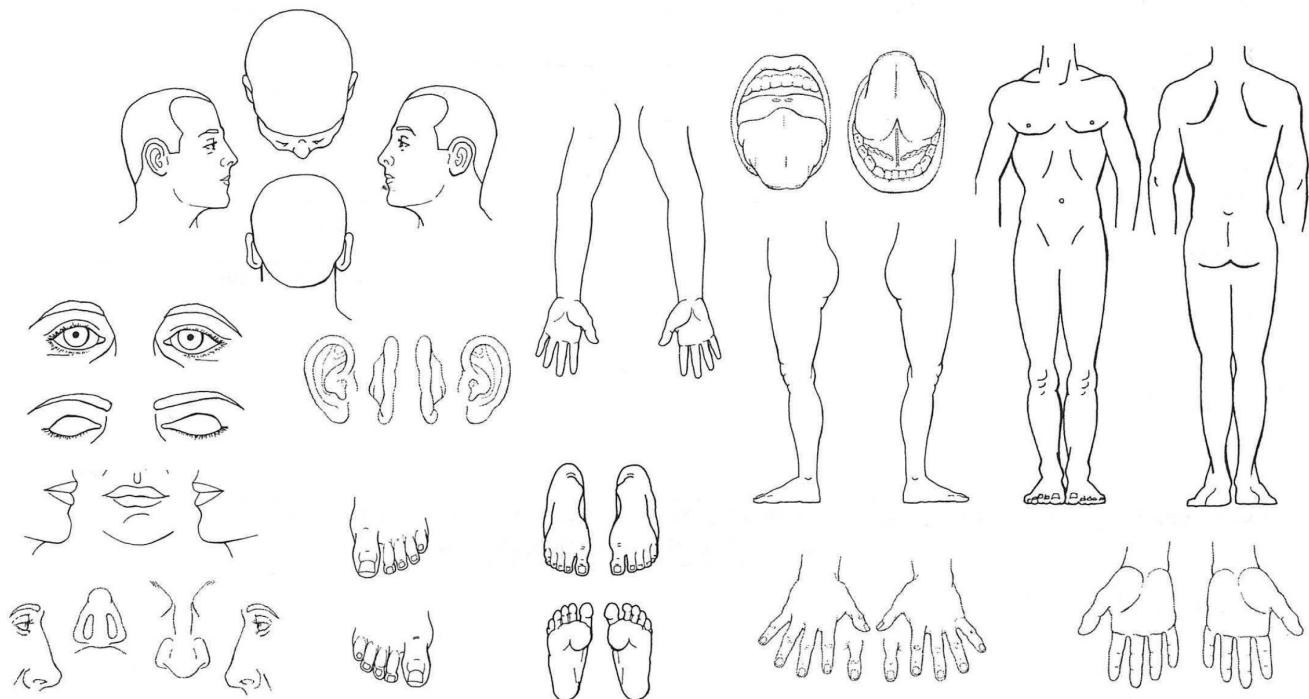
(1 - not bad and 10 - extremely bad)

1 2 3 4 5 6 7 8 9 10

For more information, contact the Academy's Practice Management Center:  
EMAIL: [coding@aad.org](mailto:coding@aad.org) • WEBSITE: [aad.org/practicecenter](http://aad.org/practicecenter)

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### CHIEF COMPLAINT: **BASAL CELL CARCINOMA**

Review and document the following medical interview question relevant to the chief complaint for each of the outlined history elements:

#### How long has it been present?

\_\_\_\_\_ Days   \_\_\_\_\_ Weeks   \_\_\_\_\_ Month

#### Where is it located?

Head   Face   Neck   Chest   Abdomen   Back   Genitalia   Shoulder (Rt/Lt)  
Upper Arm (Rt/Lt)   Forearm (Rt/Lt)   Hand (Rt/Lt)   Hip/Buttocks (Rt/Lt)   Thigh (Rt/Lt)  
Lower Leg (Rt/Lt)   Foot (Rt/Lt)

#### Any changes in the following?

Size              Yes / No  
Color              Yes / No  
Shape              Yes / No

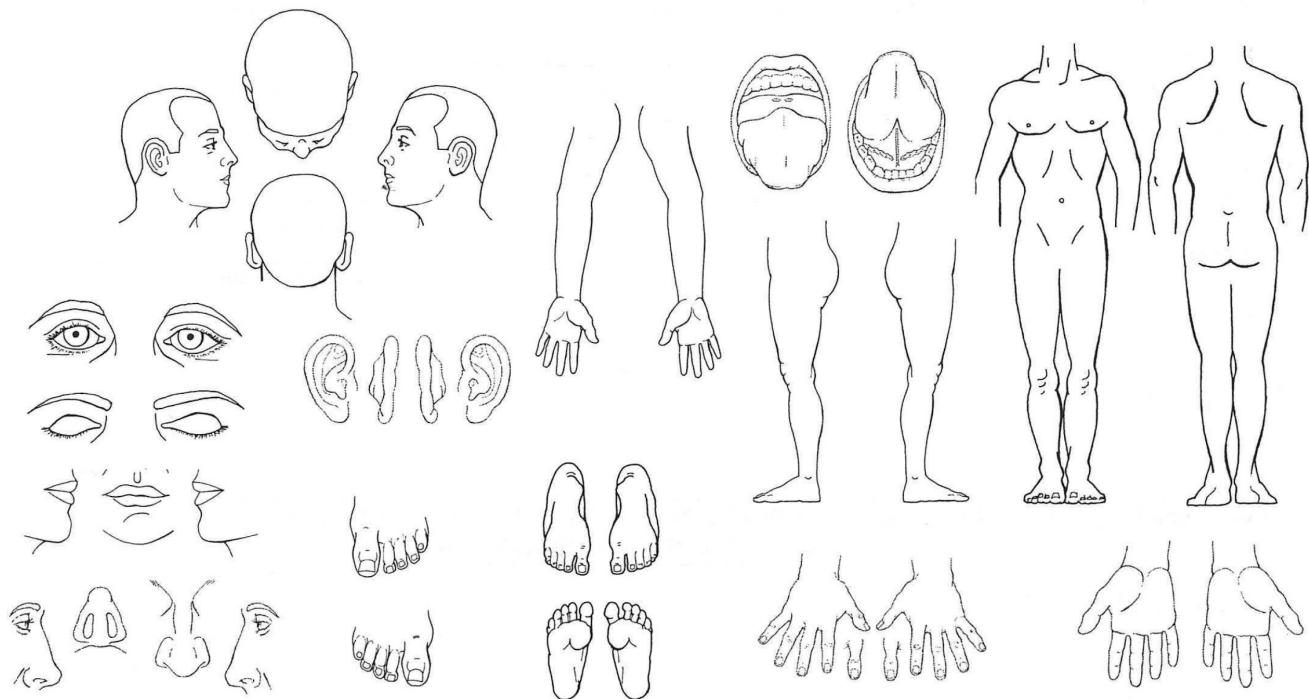
#### How would you describe it?

Itchy              Yes / No  
Painful              Yes / No  
Bleeding              Yes / No  
Non-healing              Yes / No

Is it irritated by clothing? Yes / No

#### Is it subject to trauma such as:

Cutting when shaving? Yes / No  
Gets caught in jewelry? Yes / No  
Scratching?              Yes / No  
Rubbing?              Yes / No  
Other \_\_\_\_\_



### CHIEF COMPLAINT: SQUAMOUS CELL CARCINOMA

Review and document the following medical interview question relevant to the chief complaint for each of the outlined history elements:

#### How long has it been present?

\_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Month

#### Where is it located?

Head      Face      Neck      Chest      Abdomen      Back      Genitalia      Shoulder (Rt/Lt)  
Upper Arm (Rt/Lt)      Forearm (Rt/Lt)      Hand (Rt/Lt)      Hip/Buttocks (Rt/Lt)      Thigh (Rt/Lt)  
Lower Leg (Rt/Lt)      Foot (Rt/Lt)

#### Any changes in the following?

Size      Yes / No  
Color      Yes / No  
Shape      Yes / No

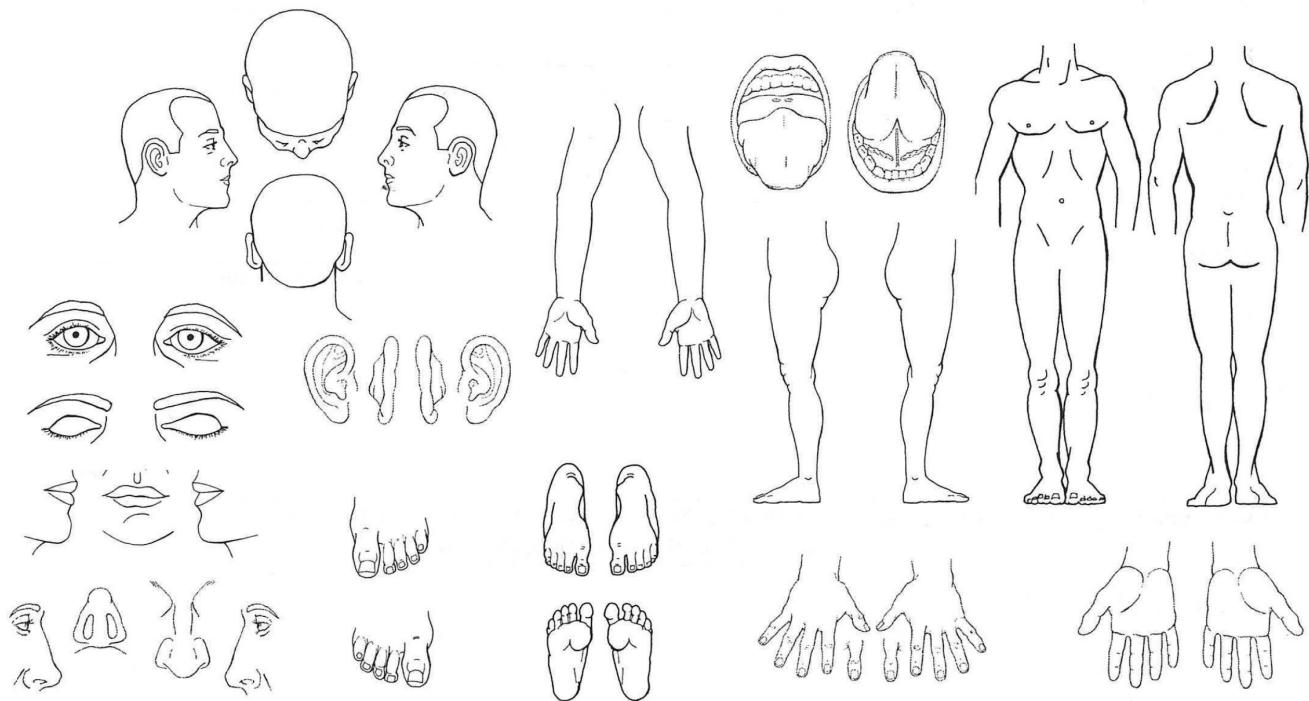
#### How would you describe it?

Itchy      Yes / No  
Painful      Yes / No  
Bleeding      Yes / No  
Non-healing      Yes / No

Is it irritated by clothing? Yes / No

#### Is it subject to trauma such as:

Cutting when shaving? Yes / No  
Gets caught in jewelry? Yes / No  
Scratching? Yes / No  
Rubbing? Yes / No  
Other \_\_\_\_\_



### CHIEF COMPLAINT: MELANOMA

Review and document the following medical interview question relevant to the chief complaint for each of the outlined history elements:

#### How long has the lesion been present?

\_\_\_\_\_ Days   \_\_\_\_\_ Weeks   \_\_\_\_\_ Month

#### Where is it located?

Head   Face   Neck   Chest   Abdomen   Back   Genitalia   Shoulder (Rt/Lt)  
Upper Arm (Rt/Lt)   Forearm (Rt/Lt)   Hand (Rt/Lt)   Hip/Buttocks (Rt/Lt)   Thigh (Rt/Lt)  
Lower Leg (Rt/Lt)   Foot (Rt/Lt)

#### Any changes in the following?

Size              Yes / No  
Color              Yes / No  
Shape              Yes / No

#### How would you describe it?

Itchy              Yes / No  
Painful              Yes / No  
Bleeding              Yes / No  
Non-healing              Yes / No

Is it irritated by clothing? Yes / No

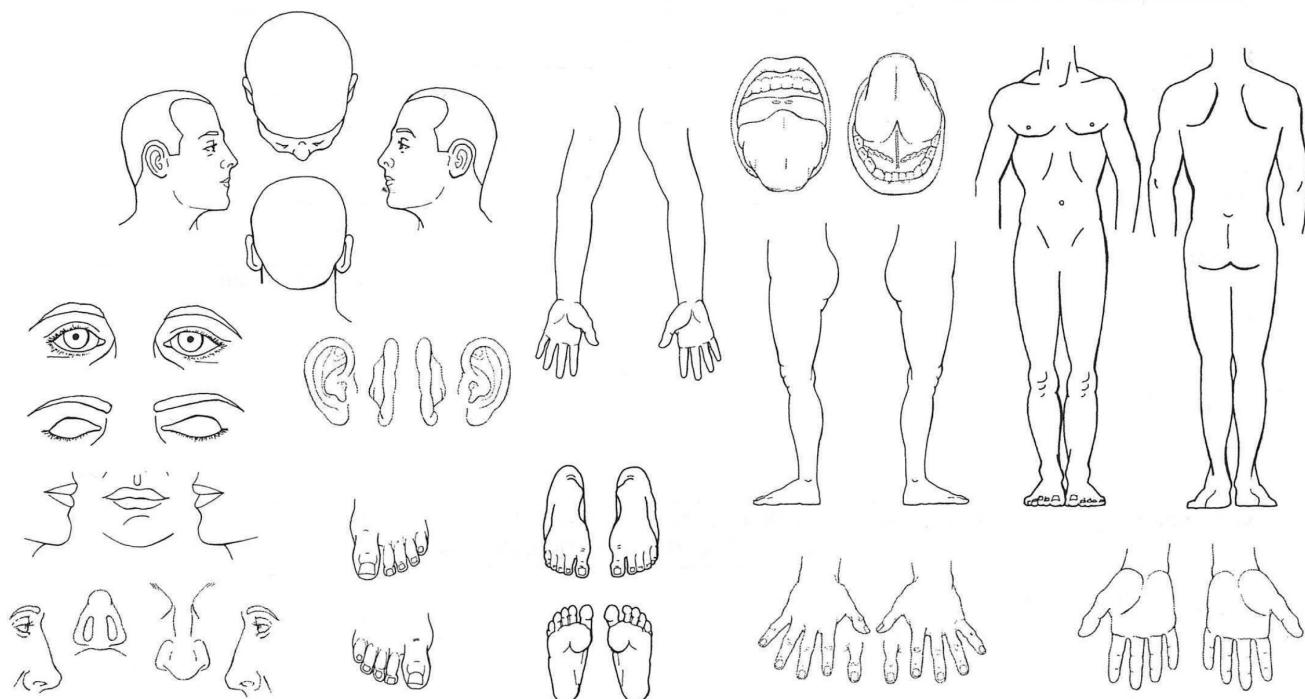
#### Is it subject to trauma such as:

Cutting when shaving? Yes / No  
Gets caught in jewelry? Yes / No  
Other \_\_\_\_\_

Are there any new moles, spots, or lumps? Yes / No

If yes, where?

Head	Face	Neck	Chest	Abdomen	Back	Genitalia	Shoulder (Rt/Lt)
Upper Arm (Rt/Lt)		Forearm (Rt/Lt)		Hand (Rt/Lt)		Hip/Buttocks (Rt/Lt)	Thigh (Rt/Lt)
Lower Leg (Rt/Lt)		Foot (Rt/Lt)					



### CHIEF COMPLAINT: SPOT (LESION, NEW MOLE, OR OTHER SPOT)

Review and document the following medical interview question relevant to the chief complaint for each of the outlined history elements:

#### How long has the lesion been present?

\_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Month

#### Where is it located?

Head	Face	Neck	Chest	Abdomen	Back	Genitalia	Shoulder (Rt/Lt)
Upper Arm (Rt/Lt)		Forearm (Rt/Lt)		Hand (Rt/Lt)		Hip/Buttocks (Rt/Lt)	Thigh (Rt/Lt)
Lower Leg (Rt/Lt)		Foot (Rt/Lt)					

#### Any changes in the following?

Size	Yes / No
Color	Yes / No
Shape	Yes / No

#### How would you describe it?

Itchy	Yes / No
Painful	Yes / No
Bleeding	Yes / No
Non-healing	Yes / No

Is it irritated by clothing? Yes / No

#### Is it subject to trauma such as:

Cutting when shaving?	Yes / No
Gets caught in jewelry?	Yes / No
Other _____	

Does anything make it better? Yes / No

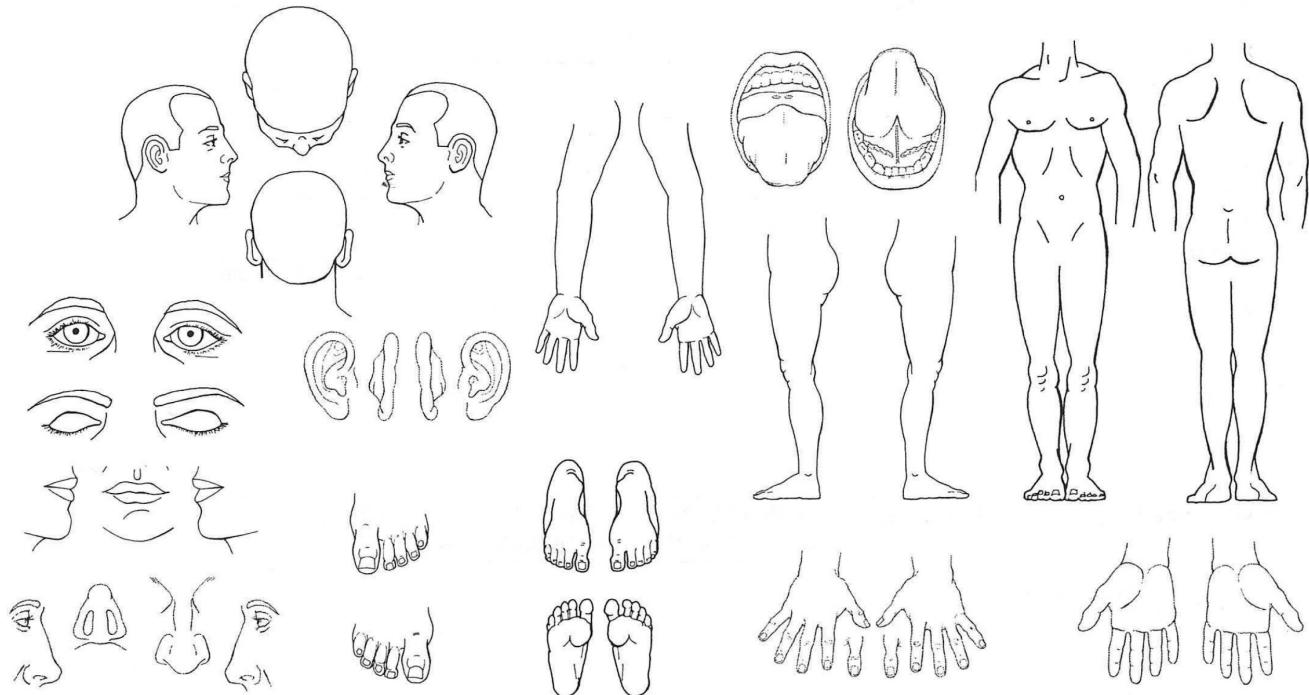
If so, what? \_\_\_\_\_

Does anything make it worse? Yes / No

If so, what? \_\_\_\_\_

Does the spot ever go away completely? Yes / No

Does anything ever drain out of the spot? Yes / No



### CHIEF COMPLAINT: ACNE

Review and document the following medical interview question relevant to the chief complaint for each of the outlined history elements:

#### How long has the lesion been present?

\_\_\_\_ Days    \_\_\_\_ Weeks    \_\_\_\_ Month    \_\_\_\_ Year

#### Where is it located?

Face    Neck    Shoulder (Rt/Lt)    Back    Chest

#### How severe is the acne?

Mild    mild to moderate    moderate    moderate to severe    severe

Are the pimples sore?    Yes / No

Do the breakouts leave scars?    Yes / No

What are your expectations of treatment? \_\_\_\_\_

#### What over-the-counter topical medication(s) are you currently using or have tried in the past?

Benzoyl peroxide    Salicylic acid    Differin    Other

Did they help reduce or alleviate the symptoms?    Yes / No

What prescription medications have you tried in the past or are currently using? \_\_\_\_\_

What was the duration of treatment?

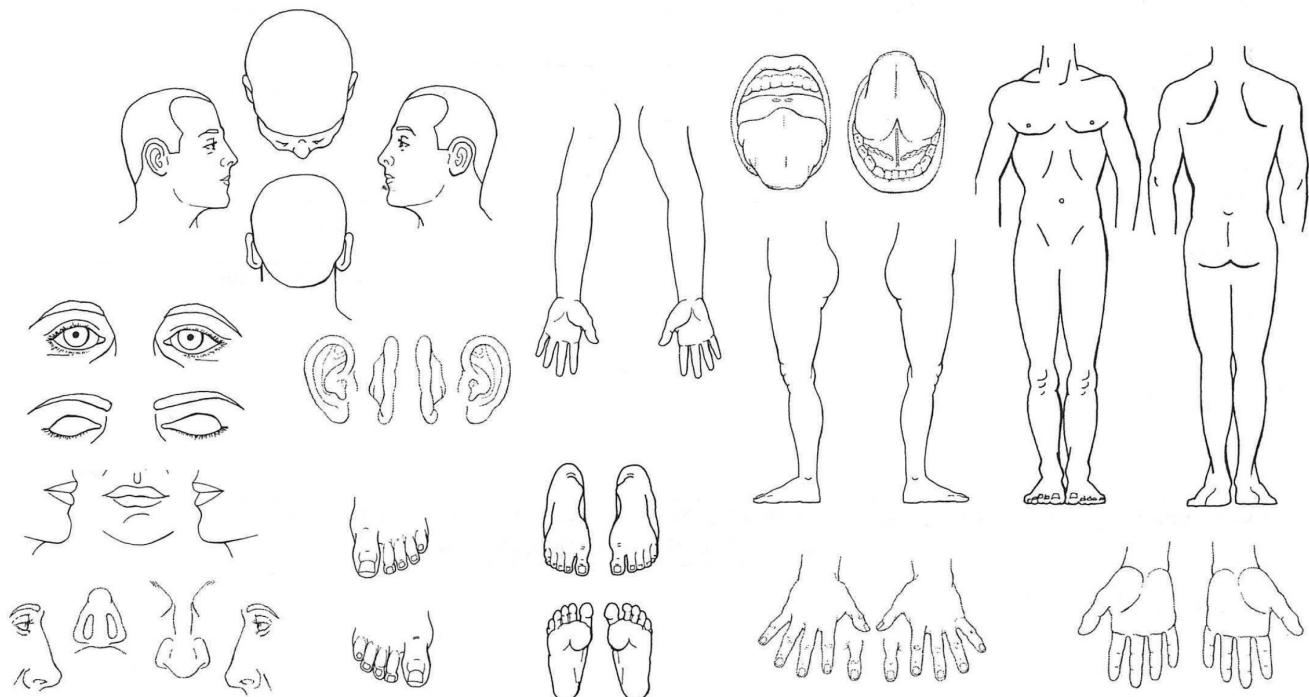
\_\_\_\_ Days    \_\_\_\_ Weeks    \_\_\_\_ Month    \_\_\_\_ Year

Did it help reduce or clear breakouts? Yes / No

Are you currently using a tanning bed or sunbathing? Yes / No

Do you ever try to "pop" or "express" the pimples? Yes / No

What types of soaps, lotions, sunscreens, hair products, or cosmetics do you use? \_\_\_\_\_



### CHIEF COMPLAINT: RASH (DERMATITIS)

Review and document the following medical interview question relevant to the chief complaint for each of the outlined history elements:

#### How long has the rash been present?

\_\_\_\_ Days    \_\_\_\_ Weeks    \_\_\_\_ Month

#### Where is it located?

Head	Face	Neck	Chest	Abdomen	Back	Genitalia	Shoulder (Rt/Lt)
Upper Arm (Rt/Lt)		Forearm (Rt/Lt)		Hand (Rt/Lt)		Hip/Buttocks (Rt/Lt)	Thigh (Rt/Lt)
Lower Leg (Rt/Lt)		Foot (Rt/Lt)					

#### Has it spread? Yes / No

If yes, where has it spread to?

Head	Face	Neck	Chest	Abdomen	Back	Genitalia	Shoulder
Upper Arm (Rt/Lt)		Forearm (Rt/Lt)		Hand (Rt/Lt)		Hip/Buttocks (Rt/Lt)s	Thigh (Rt/Lt)
Lower Leg (Rt/Lt)		Foot (Rt/Lt)					

#### How would you describe the rash?

Itchy   Yes / No  
Weepy   Yes / No  
Painful   Yes / No  
Other \_\_\_\_\_

#### Have you had this rash before? Yes / No

What prescription medications have you tried in the past or are currently using to treat the rash? \_\_\_\_\_

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Did it help reduce or alleviate the symptoms? Yes / No

**What over-the-counter medications have you tried?** \_\_\_\_\_

Did it help reduce or alleviate the symptoms? Yes / No

**Were you bitten by a tick or other insect?** Yes / No

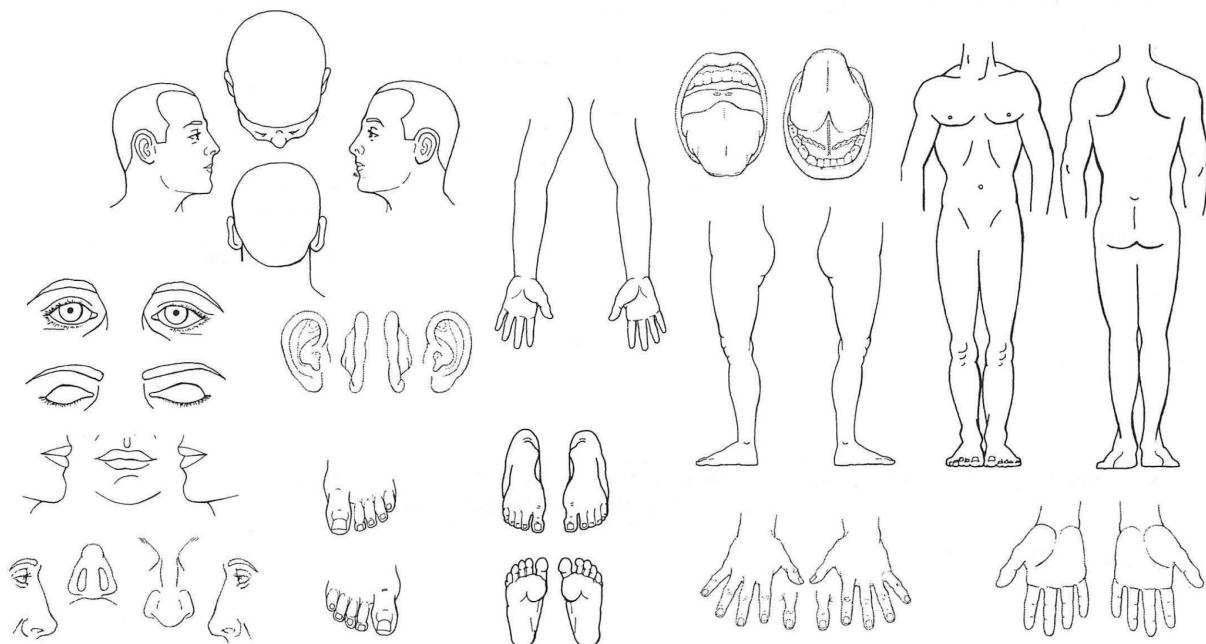
**Were there changes in any household products used, such as laundry detergent, shampoo, body wash, etc?** Yes / No

If yes, what product(s) was changed? \_\_\_\_\_

**Have you traveled recently?** Yes / No

If so, where? \_\_\_\_\_

**Have you ever had something similar in the past?** Yes / No



### CHIEF COMPLAINT: WART

Review and document the following medical interview question relevant to the chief complaint for each of the outlined history elements:

#### How long has the wart(s) been present?

\_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Month

#### Where is it located?

Head     Face     Neck     Chest     Abdomen     Back     Genitalia     Shoulder (Rt/Lt)  
Upper Arm (Rt/Lt)     Forearm (Rt/Lt)     Hand (Rt/Lt)     Hip/Buttocks (Rt/Lt)     Thigh (Rt/Lt)  
Lower Leg (Rt/Lt)     Foot (Rt/Lt)

#### Has it spread? Yes / No

If yes, where has it spread to?

Head     Face     Neck     Chest     Abdomen     Back     Genitalia     Shoulder (Rt/Lt)  
Upper Arm (Rt/Lt)     Forearm (Rt/Lt)     Hand (Rt/Lt)     Hip/Buttocks (Rt/Lt)     Thigh (Rt/Lt)  
Lower Leg (Rt/Lt)     Foot (Rt/Lt)

#### Has it changed in appearance or color? Yes / No

#### Is it blocking an orifice?     Yes / No

If yes, which orifice?

Mouth     Nasal     Anal     Urethral

#### Is it obstructing vision?     Yes / No

If yes, which eyelid?

Rt            Lt  
Upper      Lower

**Does the wart cause discomfort?**      Yes / No

**Would you describe it as**

Itchy?           Yes / No  
Weepy?          Yes / No  
Painful?         Yes / No

**Is it irritated by clothing?**      Yes / No

**Is it subject to trauma such as:**

Cutting when shaving? Yes / No  
Gets caught in jewelry? Yes / No  
Other \_\_\_\_\_

**What over-the-counter treatments have you tried?** \_\_\_\_\_

How long did you use this treatment?

\_\_\_\_\_ Days    \_\_\_\_\_ Weeks    \_\_\_\_\_ Month

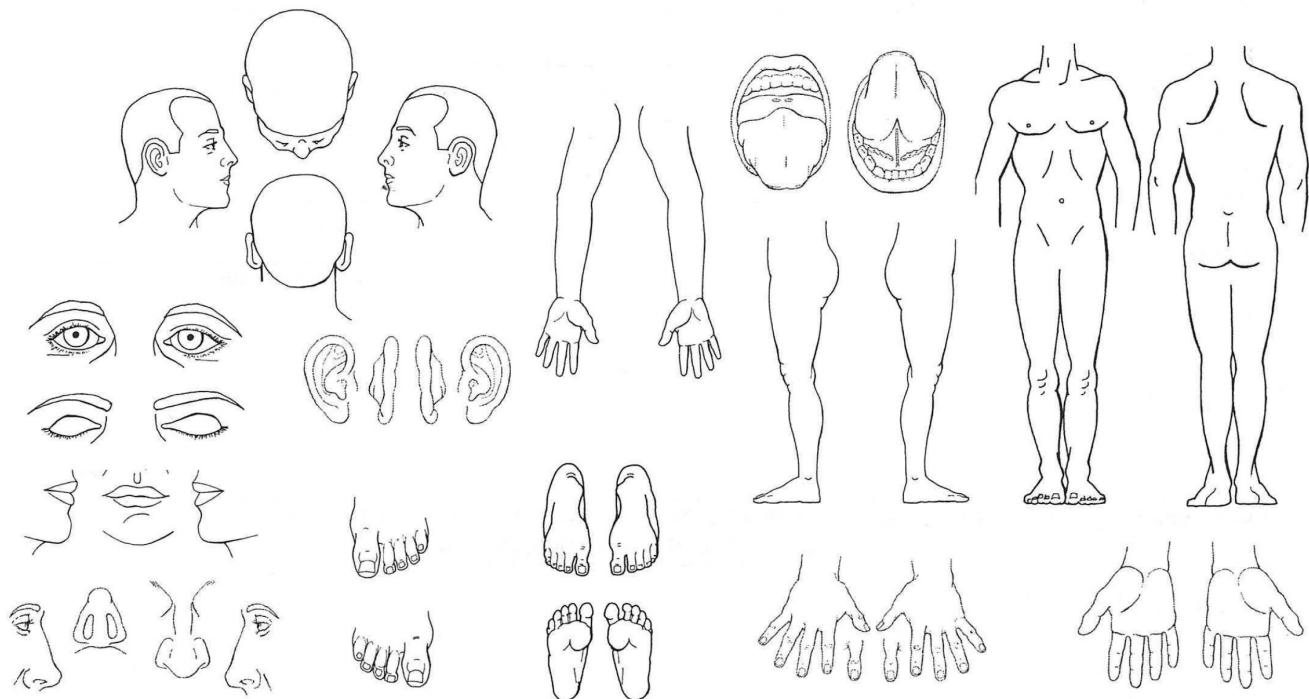
Did they help reduce or alleviate the symptoms?      Yes / No

**Did the wart return after completion of treatment?**      Yes / No

**Have you used any prescription medications for it, such as imiquimod or tretinoin?**      Yes / No

If yes, what prescribed medication did you use? \_\_\_\_\_

**Have you had treatment in the past with a healthcare provider?**      Yes / No



### CHIEF COMPLAINT: ATOPIC DERMATITIS/ECZEMA

Review and document the following medical interview question relevant to the chief complaint for each of the outlined history elements:

#### How long has the eruption been present?

\_\_\_\_\_ Days \_\_\_\_\_ Weeks \_\_\_\_\_ Month

#### Where is it located?

Head      Face      Neck      Chest      Abdomen      Back      Genitalia      Shoulder (Rt/Lt)  
Upper Arm (Rt/Lt)      Forearm (Rt/Lt)      Hand (Rt/Lt)      Hip/Buttocks (Rt/Lt)      Thigh (Rt/Lt)  
Lower Leg (Rt/Lt)      Foot (Rt/Lt)

#### On a scale of 1-10 how bad is the eruption?

(1- not bad and 10 - extremely bad)

1 2 3 4 5 6 7 8 9 10

#### How would you describe the rash?

Itchy      Yes / No

Painful      Yes / No

Bleeding      Yes / No

Are there blisters?      Yes / No

Is the skin dry or scaly?      Yes / No

Have you had this rash before? Yes / No

What prescription medications are you currently using for the rash? \_\_\_\_\_

Does it help reduce or alleviate the symptoms?      Yes / No

How often do you use the prescription medication? \_\_\_\_\_

**What prescription medications have you tried in the past?** \_\_\_\_\_

How long did you try it for? \_\_\_\_\_

Did it help reduce or alleviate the symptoms? Yes / No

**What over-the-counter medications have you tried?** \_\_\_\_\_

How long did you try it for? \_\_\_\_\_

Did it help reduce or alleviate the symptoms? Yes / No

**Are there signs of infection in the area of the eruption?** Yes / No

Oozing Yes / No

Bleeding Yes / No

**How often do you bathe?** \_\_\_\_\_

How warm or cold is the water when you bathe?

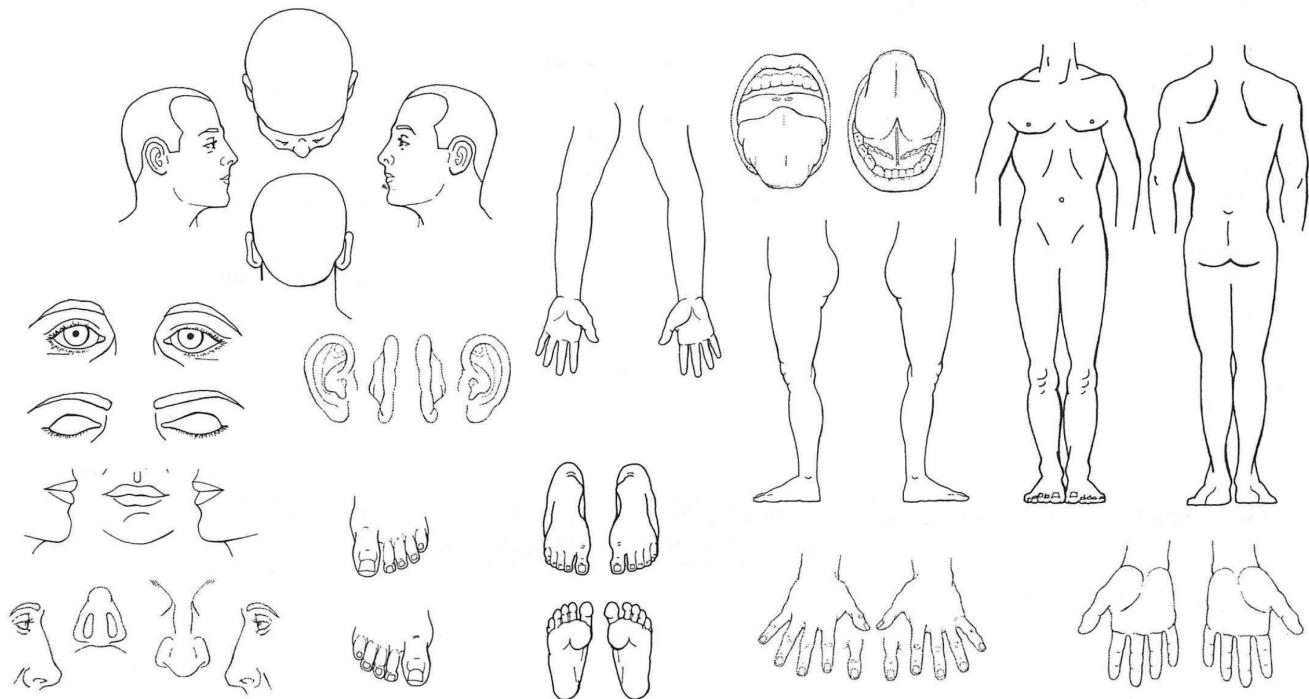
Very Hot Hot Lukewarm Cold Water

**Do you use any over-the-counter moisturizers?** Yes / No

How often do you use the moisturizer? \_\_\_\_\_

**Have you ever had a biopsy of the rash before?** Yes / No

**Was the rash diagnosed as eczema?** Yes / No



Reviewed 10/17/2024

For more information, contact the Academy's Practice Management Center:  
EMAIL: [practicecenter@aad.org](mailto:practicecenter@aad.org) • WEBSITE: [aad.org/practicecenter](http://aad.org/practicecenter)

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