

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.

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

For more information, contact the Academy's Practice Management Center:

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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

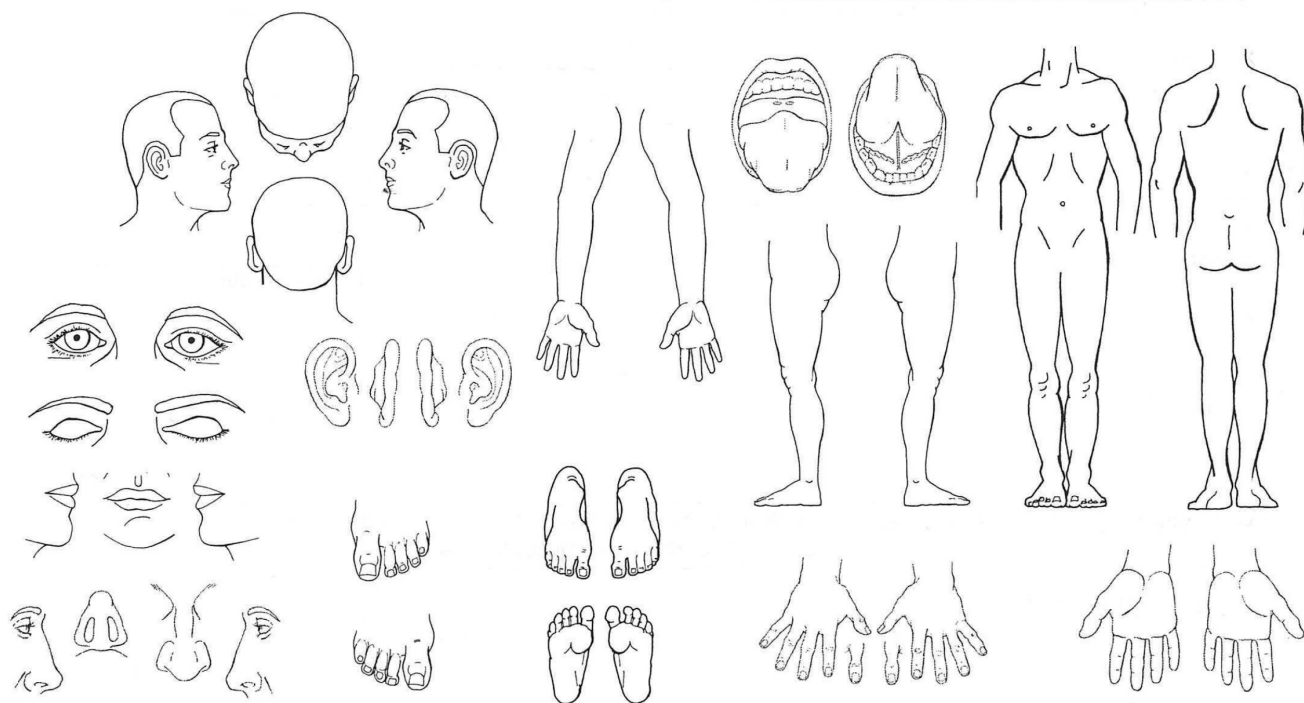
If so, what are they? _____

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



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

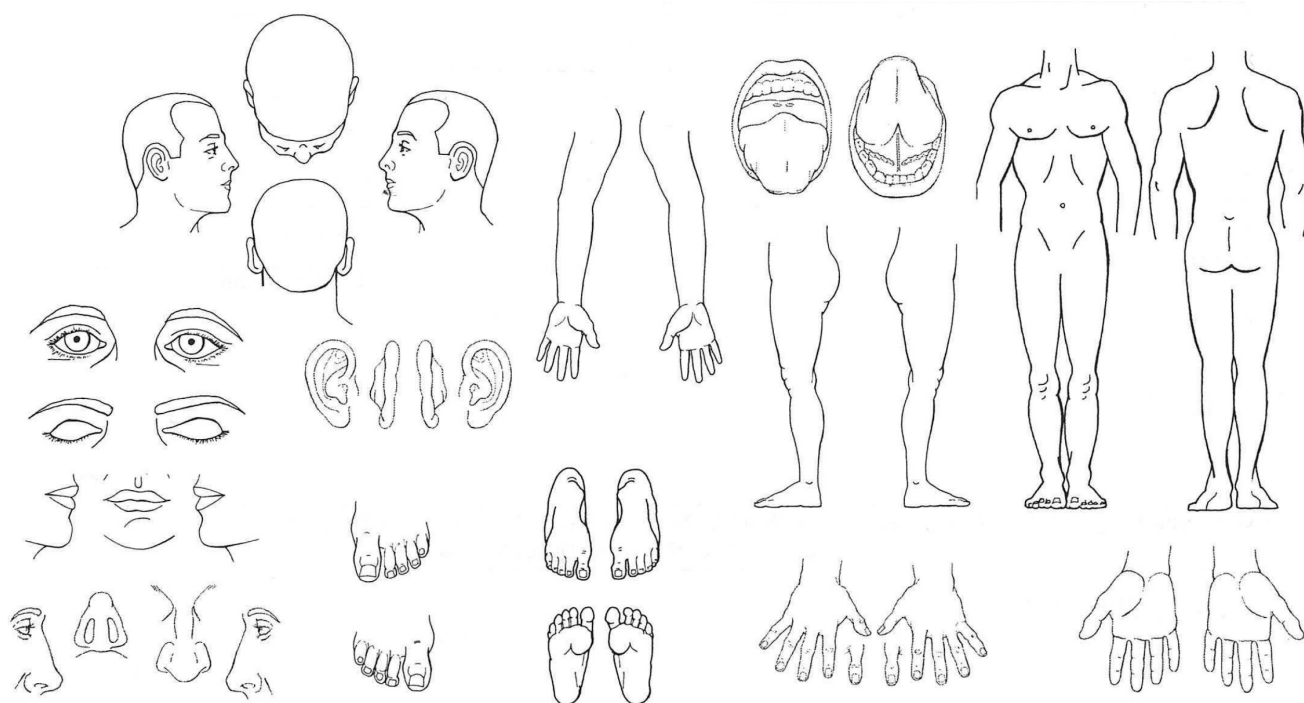
How would you describe it?

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 _____



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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

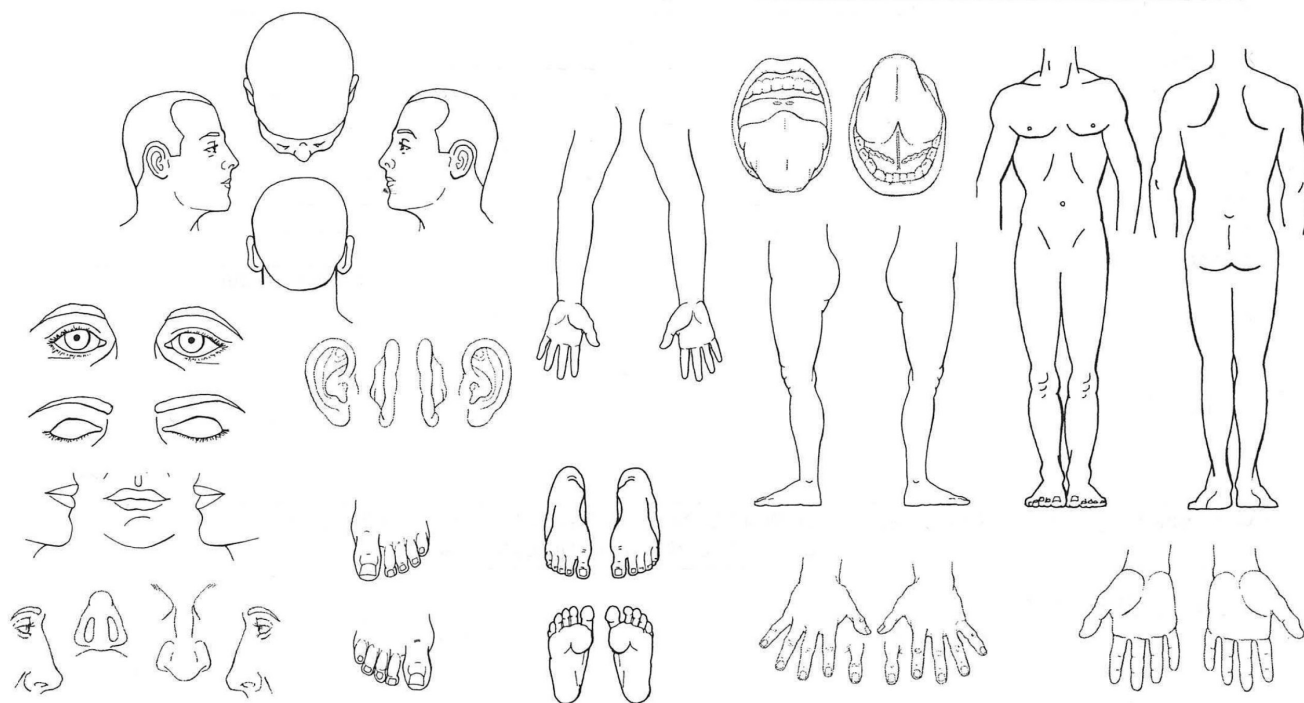
How would you describe it?

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

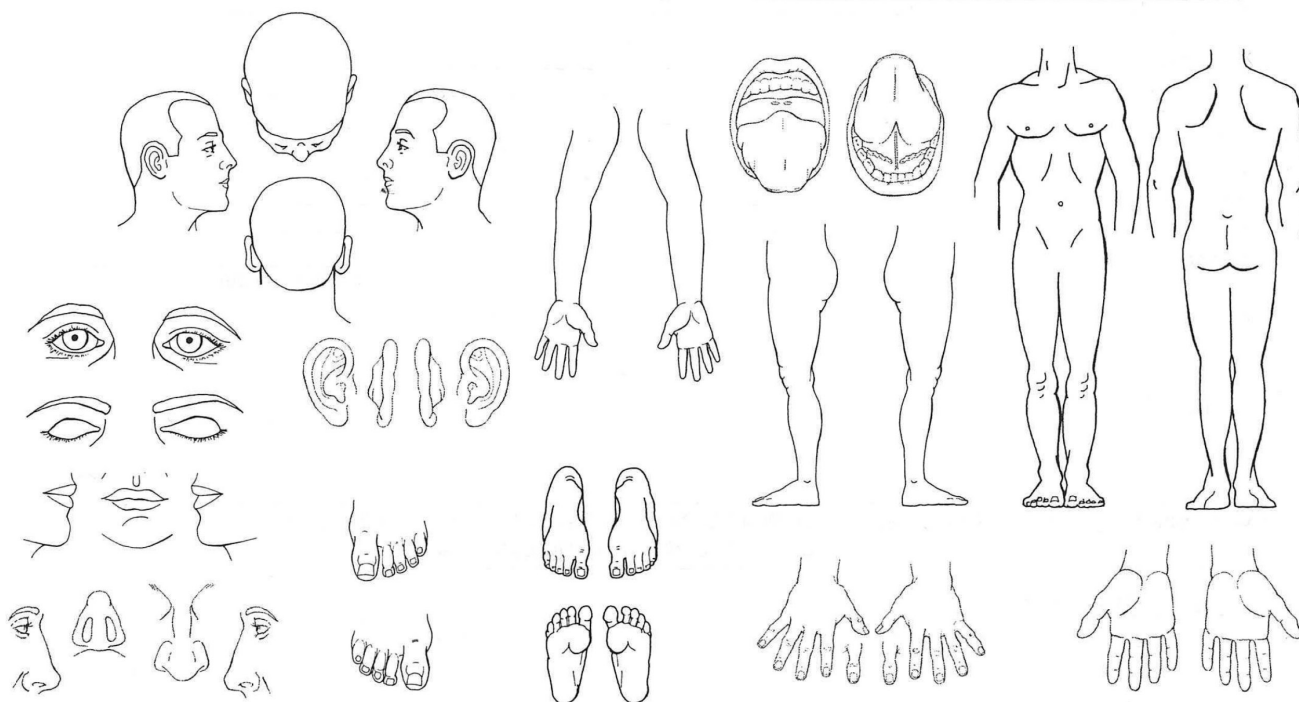
Is it subject to trauma such as:

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

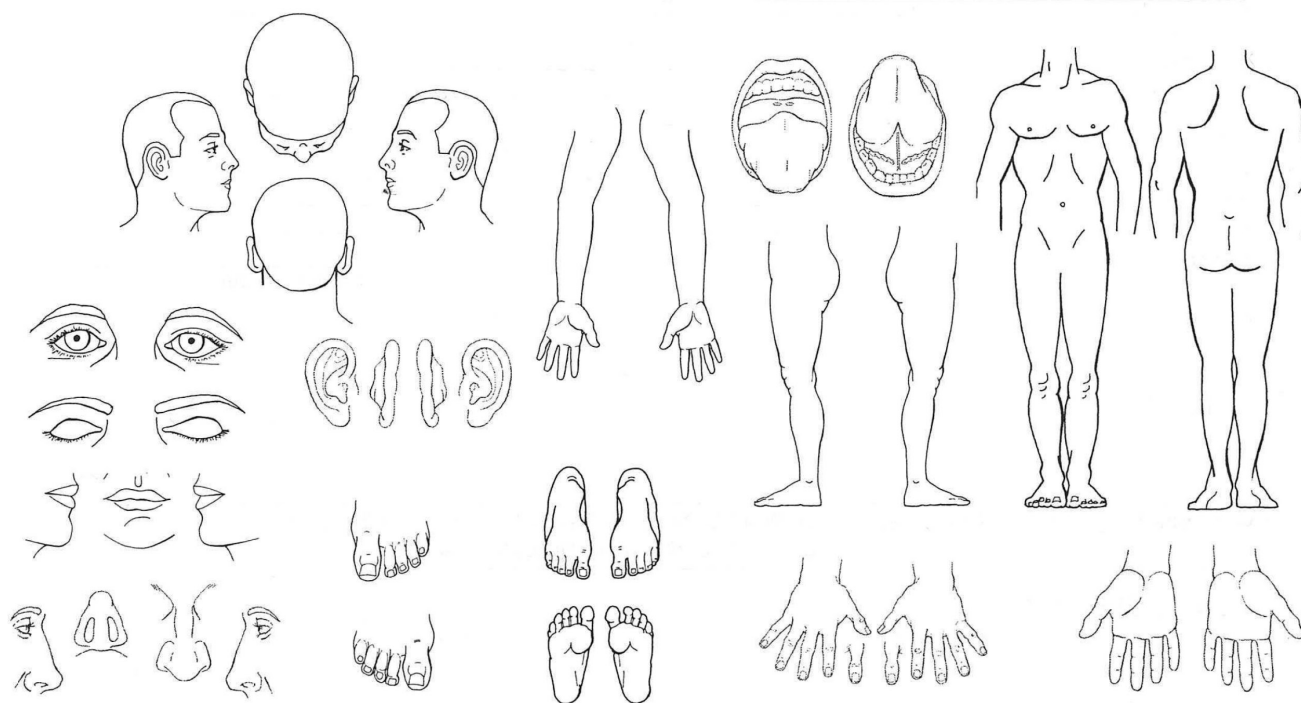
If so, what? _____

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



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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?

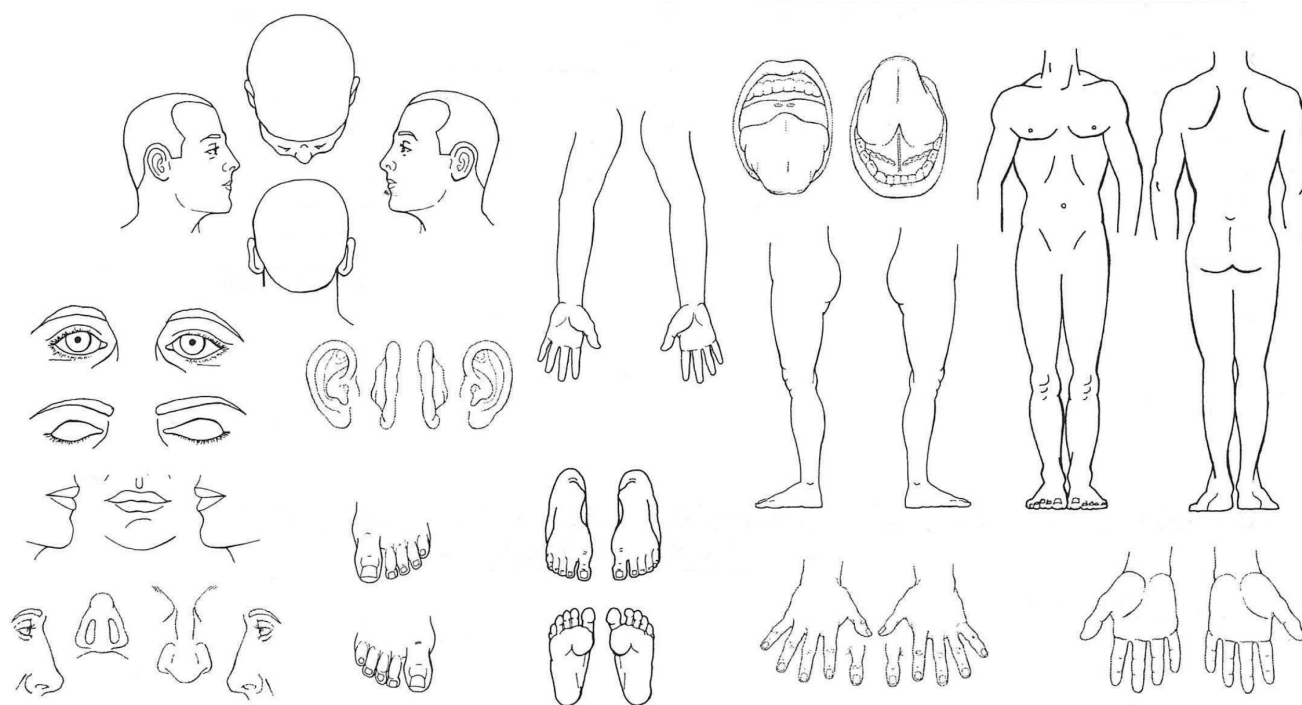
_____ Days _____ Weeks _____ Month _____ Year

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? _____

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

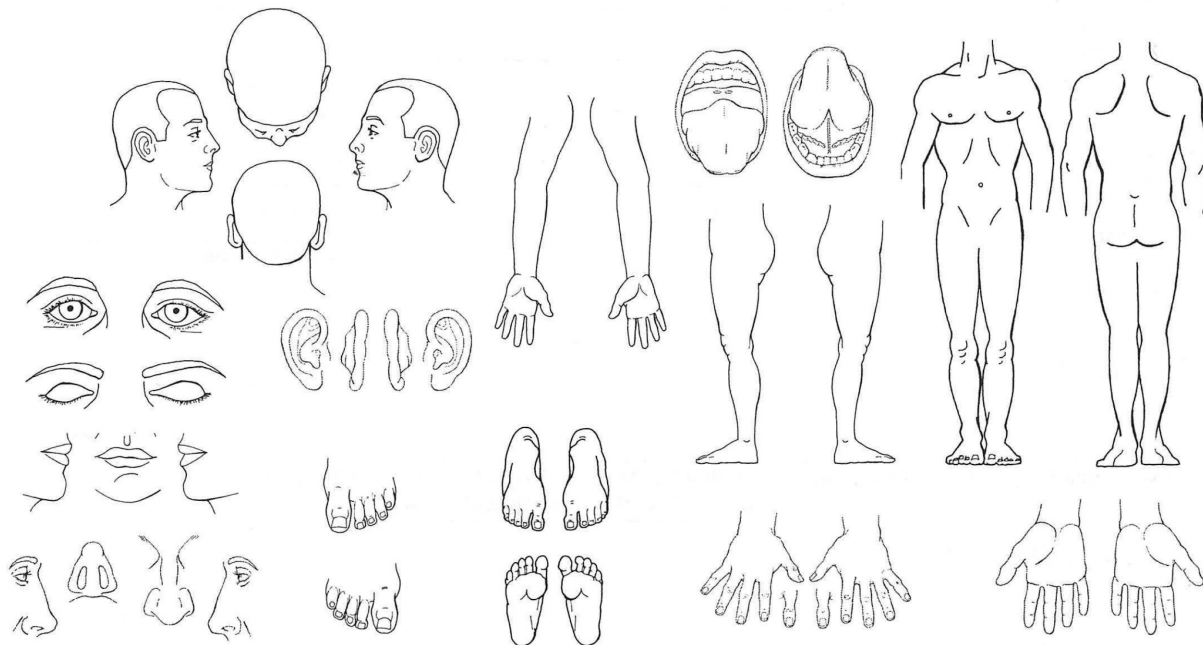
Were there changes in any household products used, such as laundry detergent, shampoo, body wash, etc? Yes / No

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

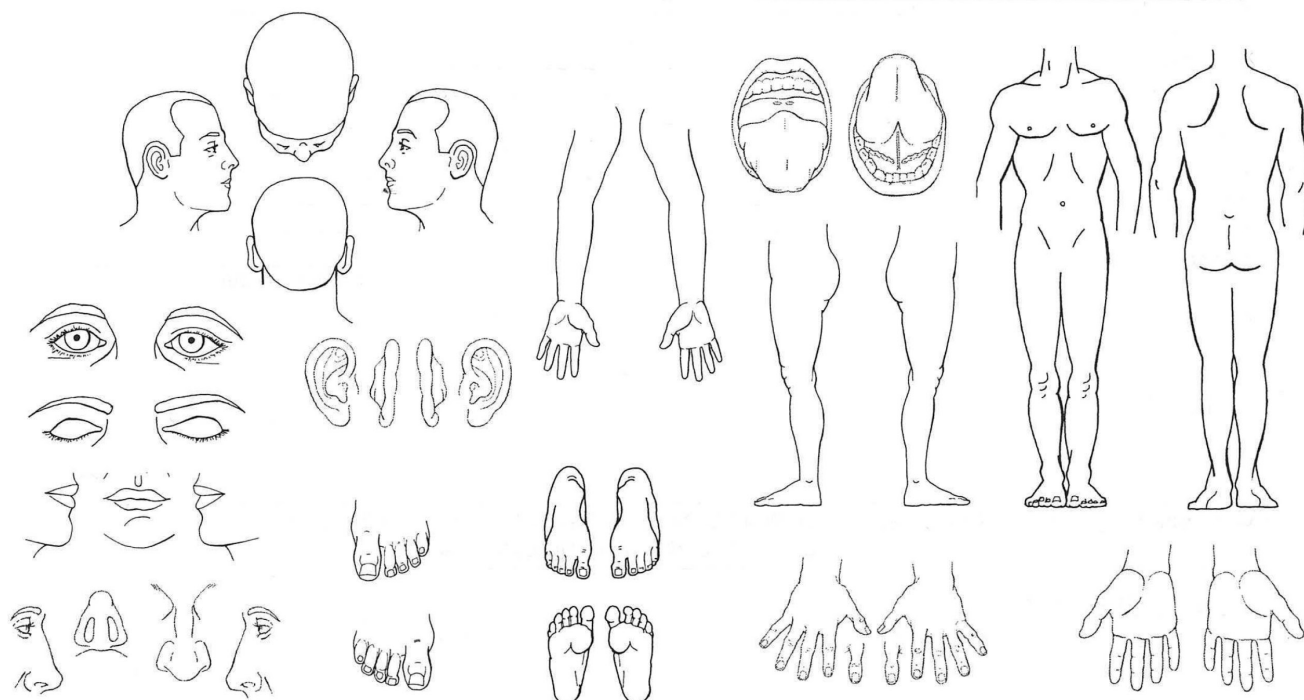
Did they help reduce or alleviate the symptoms? Yes / No

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?

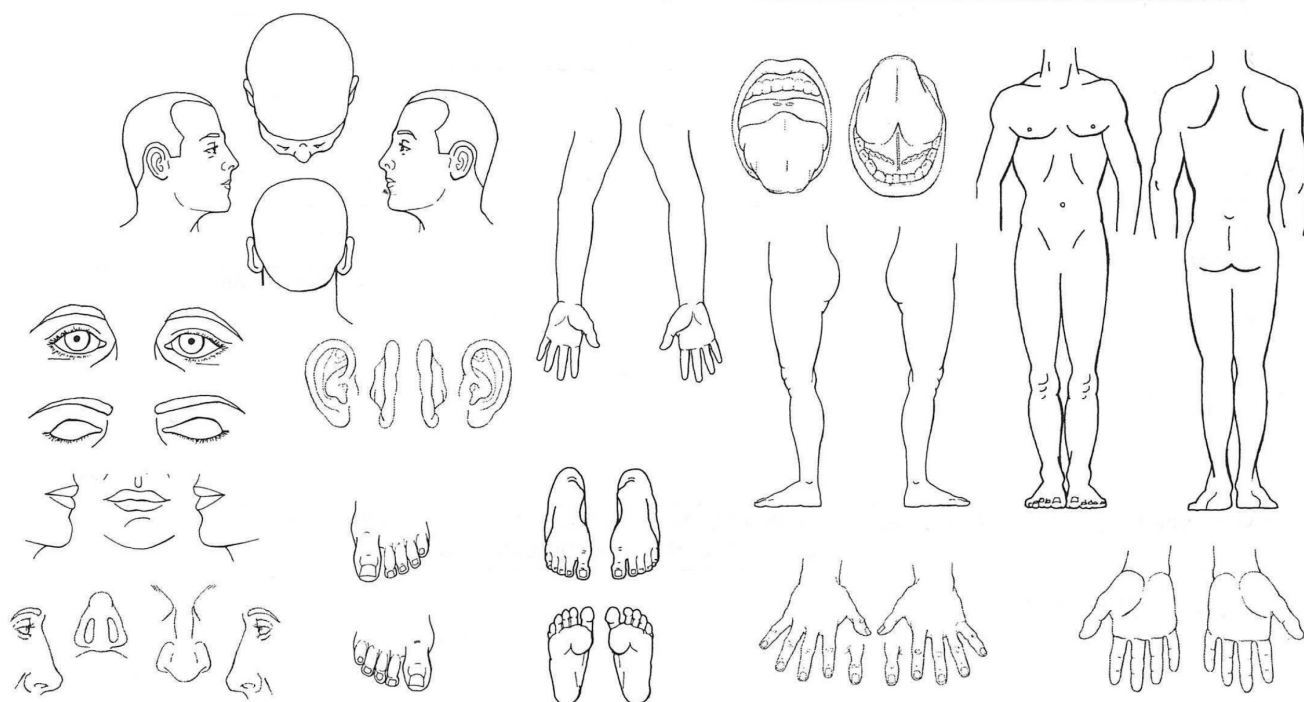
Very Hot Hot Lukewarm Cold Water

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



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