Teledermatology Patient Questionnaire

Name: NHS number (if known):

Date of birth: Date of clinic:
Location of clinic:
Address: Photographer:

	Y	N
Where is the mark that has caused you or your GP concern and how long has it been present? …….		
Has the mark changed?	☐	☐
If yes, how long ago did you first notice the change? …..……		
Is it painful or tender to touch?	☐	☐
Does it bleed without being scratched or picked?	☐	☐
Have you or your GP tried any treatment?	☐	☐
If yes, please describe the treatment tried…….		
Have you worked outdoors for more than 10 years in your life?	☐	☐
Do you burn easily in the sun?	☐	☐
Do you have an organ transplant or take medicine that alters your immune system	☐	☐
If yes, please give details ……		
Do you have a heart pacemaker?	☐	☐
Do you take medicine that makes you bleed more easily *('blood thinners')*?	☐	☐
If yes, please name it: ……		
Do you have an allergy to medications or creams or wound dressings?	☐	☐
If yes, please name it: ……		
Have you had skin cancer in the past? If yes:	☐	☐
Please provide detail of when, the name of the cancer and where it was treated ……..		
Is there a family history of skin cancer?	☐	☐
If yes, could you name the type of cancer……		
Do you have mobility problems or requirements?	☐	☐
If yes, please provide details……		
Would you be happy to provide feedback on this new service?	☐	☐
If yes, how would you like to be contacted?.....		