

**Patient's Name:** \_\_\_\_\_

**Patient's Date of Birth:** \_\_\_\_\_

**Concern (circle one):**            wart            molluscum            skin bump (uncertain)

**Areas of body (circle all):**

scalp   face   neck   chest   abdomen   back   buttocks   arms   legs   palms   soles   top of  
hands/fingers   top of feet/toes   genital area

**How long present:** \_\_\_\_\_ (months/years)

**Associated symptoms (circle all):**            pain            itch            bleeding

**Treatments attempted (circle all):**            Home wart liquid/plaster medicine or wart bandaids

Home freezing kit

Wart freezing at PCP office

Other: \_\_\_\_\_

**Any medical issues (eg, asthma, allergies, diabetes, etc):** \_\_\_\_\_

**List current medications:** \_\_\_\_\_

**Any allergy to medications or food:** None

**OR list allergies to medications or food:** \_\_\_\_\_

**Any skin diseases in the family? Please list condition and in whom:** \_\_\_\_\_

**Any pets in home (indoor or outdoor):** dogs   cats   birds   snake/lizard/turtle   other \_\_\_\_\_