ARIZONA NATUROPATHIC MEDICINE LLC

Warts, Moles, Skin Tags

Patient Name: ________________________________ **Date of Birth/Age:** _________ **Date:** __/___/_______

When did these skin growth begin?
__ At birth __ Adolescence __ Adult __Recently

Have you noticed any changes in the growths?
__ N __ Size __ Color __ Shape __ Number

Is there now or recently bleeding associated with the skin growth? Y N

Have you seen other doctors for this? Y N
__Primary Care ___ Dermatology __ Other
If yes, were you provided a diagnosis: Y N

What treatment was tried? None

____
____
____

Where are your growths? Estimate Number

- Face 1…3…6 7 8 9 10
- Neck 1…3…6 7 8 9 10
- Upper Back 1…3…6 7 8 9 10
- Mid Back 1…3…6 7 8 9 10
- Lower Back 1…3…6 7 8 9 10
- Upper Thigh R L 1…3…6 7 8 9 10
- Lower Thigh R L 1…3…6 7 8 9 10
- Bottom of Foot R L 1…3…6 7 8 9 10
- Shoulder R L 1…3…6 7 8 9 10
- Hand R L 1…3…6 7 8 9 10
- Abdomen 1…3…6 7 8 9 10
- Chest/Breast R/L 1…3…6 7 8 9 10
- Around the anus 1…3…6 7 8 9 10

____

Females:

- On or around the labia Y N
- On or around the vagina Y N
- On or around the clitoris Y N
- Other: ___________________________

Males:

- On the shaft of the penis Y N
- On the head of the penis Y N
- On the scrotum Y N
- Other: ___________________________

How would you describe the skin growths?
__ Fleshy, soft
__ Hard, painless
__ Hard, painful

Does the growths keep you from doing what you want or need to do? __Y __N

For Women of Childbearing Potential Only

- Are you, or could you be, pregnant? Y N
- If yes, do you plan to breastfeed? Y N

Known Drug Allergies:
Medication: __________________________________ Reaction: ________________ Last Taken: __________
Medication: __________________________________ Reaction: ________________ Last Taken: __________
Medication: __________________________________ Reaction: ________________ Last Taken: __________

Signature of Patient

____ ______________________
Signature Date