Skin Cancer Clinic Screening Form

Primary Care Provider

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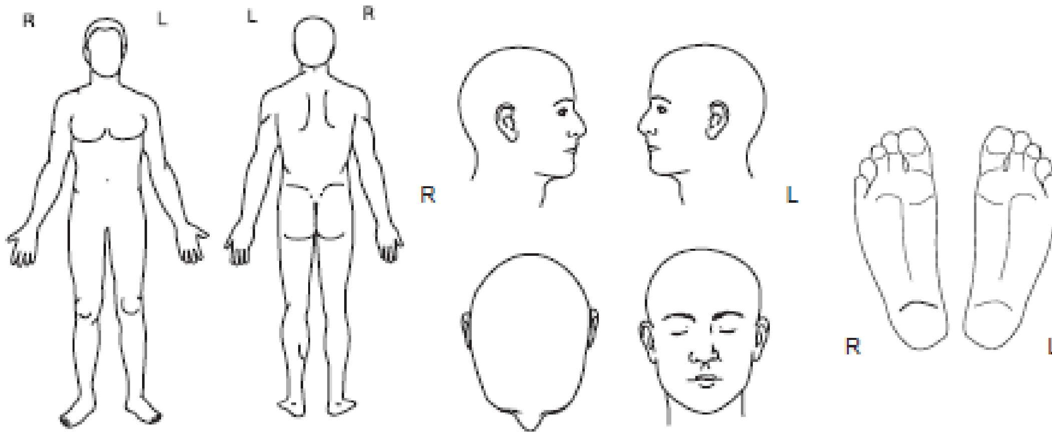
	Yes	No
Have you ever had skin cancer before? *(Please circle)*	Yes	No
Do you wear sunscreen?	Yes	No
Have you ever had a skin cancer screening exam?	Yes	No



Recommendation:

______________________________ ______________________________

Provider Signature Date/Time

I understand that I am responsible for my own health. I understand that the purpose of this screening is to detect cancerous or precancerous skin conditions only. I understand that if a precancerous or cancerous condition is detected, that it is my responsibility to arrange for additional follow-up or care.

Patient Signature: ______________________________ Date/Time: ______________________________

PATIENT ID/LABEL