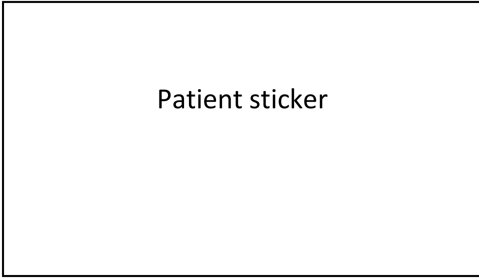
NHS

Chelsea and Westminster Hospital
NHS Foundation Trust



Date: ________________

Photographer:______________________

For photography staff:
Is this patient able to complete this form? Yes ☐ No ☐
Any history of dementia or learning difficulties? Yes ☐ No ☐

Age: ______________________________

Present occupation: ____

Previous occupations: ____

PRESENTING COMPLAINT

Where on your body is the lesion for which you have been referred? ___________________________

How long have you had this lesion? ____

When did this lesion change? ____

Has this lesion changed in the **last 3 months?** (please tick)	Yes ☐	No ☐
Has the lesion changed: **in size**?	Yes ☐	No ☐
in shape?	Yes ☐	No ☐
in colour?	Yes ☐	No ☐

Has it been: Itchy/ crusty or rough/ oozing/ bleeding/ painful (please **circle any that are applicable**)

Have **you** had a previous skin cancer:	Yes ☐	No ☐

If so, **was this a:** BCC ☐ SCC ☐ Melanoma ☐ Don't know ☐

Has a member of your family ever had skin cancer?	Yes ☐	No ☐
Do you sunburn easily?	Yes ☐	No ☐
Have you ever lived somewhere hot and sunny?	Yes ☐	No ☐
Have you ever worked outside regularly?	Yes ☐	No ☐
Do you have any hobbies that take place outside?	Yes ☐	No ☐
Have you ever used sun beds?	Yes ☐	No ☐
Did you ever have severe or blistering sun burn as a child?	Yes ☐	No ☐

Are you immunosuppressed (have a suppressed immune system) Yes ☐ No ☐

If so, **is this due to (please tick as appropriate):**

- Organ transplant ☐
- Medication eg: methotrexate, ciclosporin, chemotherapy, long term steroids ☐
- Cancer (any type) ☐
- Illness (eg: rheumatoid arthritis or HIV) ☐

In the event that you need a biopsy

Do you have any medication allergies? Yes ☐Details___________ No ☐

Do you have a pacemaker? Yes ☐ No ☐

Are you on any blood thinning agents? Yes ☐(Please circle below) No ☐

Aspirin/ warfarin/ clopidogrel/ dipyridamole/rivaroxiban/ apixiban/ dabigatran

Do you have any blood borne viruses? Yes ☐(Please circle below) No ☐

HIV/Hepatitis B/Hepatitis C

Are you pregnant or breast feeding? Yes ☐ No ☐

Consent to Clinical Photography

Please tick the relevant box and then sign below (patient or person responsible for the patient (1) and by the requesting photographer/doctor (2)).

I consent to the production of clinical photographs/video recordings for my medical record

Yes ☐ No ☐

I consent that these images can be used anonymously for teaching and research which may include training (including computer learning) to improve the diagnosis/management of skin conditions.

Yes ☐ No ☐

1. Signed ______________________________________ (patient)
2. Signed ______________________________________ (photographer/doctor)

For photography Staff:

Patient has copy of patient information leaflet Yes □ No □

Patient questionnaire checked & completed adequately? Yes □ No □

Signed consent for photography obtained? Yes □ No □

Questionnaire & lesion photographed (inc dermoscopic views)? Yes □ No □