

Name	Date of birth
Employer	

In order to make a correct assessment of your risk for malignant melanoma, we require some additional information. Please circle as applicable.

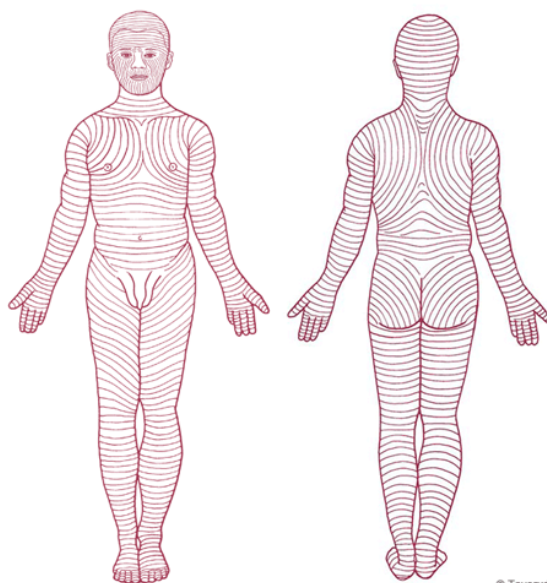
We do not have the capacity to perform a general skin check- up.

Please limit the area to be examined to 1-4 moles.

Have you, or anyone in your family, had skin cancer?	Yes	No
Relationship:	Type:	

Have you use or have you used tanning beds?	Yes	No			
Do you use suncream?	Yes	No	Sometimes		
Factor (SPF)	15	20	25	30	50+
Do you use sunglasses?	Yes	No	Sometimes		
Do you or have you used immune suppressant medications?	Yes	No			
Do you have a sun sensitive skin type?	Yes	No			
Have your previously removed any malign melanoma ?	Yes	No			

Please mark with an x where you have noticed a skin alteration.



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1	2
A	A
B	B
C	C
D	D
E	E
*	*
3	4
A	A
B	B
C	C
D	D
*	*

RECOMMENDATIONS\* : 1 Removal by your family practitioner    2 Removal by an AKER CARE physician     
 3 Referral to a dermatologist    4 Control in \_\_\_ months    5 No follow up required