

PATIENT DERMATOLOGY & ALLERGY HISTORY

Patient name: _____ Date: _____

Patient age: _____ Sex: Male Female Occupation: _____

Race: White Hispanic Black/African-American Asian American Indian Other

Existing Conditions:

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Cardiovascular Disease _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Depression _____
<input type="checkbox"/> Alcohol/Drug Abuse _____	<input type="checkbox"/> Liver Disease _____
<input type="checkbox"/> High Cholesterol _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Lung/Respiratory Disease _____	<input type="checkbox"/> Neurological Disorders _____
<input type="checkbox"/> Infectious Disease _____	<input type="checkbox"/> Allergies _____
<input type="checkbox"/> Pregnancy _____	<input type="checkbox"/> Menopause _____
<input type="checkbox"/> Immune disorders _____	<input type="checkbox"/> Puberty _____
<input type="checkbox"/> Obesity _____	<input type="checkbox"/> Skin Disorders _____
<input type="checkbox"/> Other: _____	

Current Medicines: OTC & Rx (dates, dosage)

<input type="checkbox"/> Vitamins/Minerals _____	<input type="checkbox"/> Herbs _____
<input type="checkbox"/> NSAIDs _____	<input type="checkbox"/> Aspirin _____
<input type="checkbox"/> Asthma Medications _____	<input type="checkbox"/> Antihistamines _____
<input type="checkbox"/> Oral contraceptives _____	<input type="checkbox"/> Thyroxin _____
<input type="checkbox"/> Sedatives/Sleep Aids _____	<input type="checkbox"/> Steroids (nasal/topical) _____
<input type="checkbox"/> Rx Pain Meds _____	<input type="checkbox"/> Antidepressants _____
<input type="checkbox"/> Oral hypoglycemics _____	<input type="checkbox"/> Insulin _____
<input type="checkbox"/> Hormones _____	<input type="checkbox"/> Antibiotics/Antifungals _____
<input type="checkbox"/> Diuretics _____	<input type="checkbox"/> Other BP Medications _____
<input type="checkbox"/> Statins _____	<input type="checkbox"/> Anticoagulants _____
<input type="checkbox"/> Other _____	

Medical Devices: (including dental)

<input type="checkbox"/> Implants _____	<input type="checkbox"/> Stents _____
<input type="checkbox"/> Braces _____	<input type="checkbox"/> Fillings _____
<input type="checkbox"/> Crowns/Bridges _____	<input type="checkbox"/> Other: _____

Current Complaint: _____

Date of onset and/or duration: _____

AT ONSET: Area(s) affected _____

Severity: Mild Moderate Severe

Type and pattern of eruption: _____

NOW: Area(s) affected _____

Severity: Mild Moderate Severe

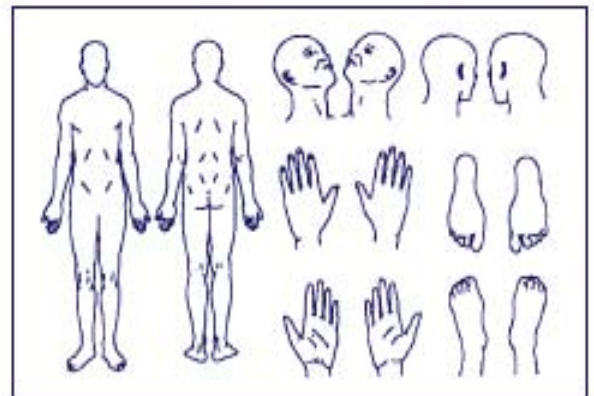
Currently: Stable Increasing Decreasing

Worsens during: Work week Weekends Improves during: Weekend Holidays/vacations

Outbreak frequency: Weekly Monthly Annual Seasonal

Previous Outbreaks: No Yes, on date(s) : _____

Self-treat: No Yes Physician treat: No Yes, on date(s): _____



History of allergic disorders: Childhood eczema Asthma Hay fever Urticaria
 Food allergy: Suspected Known: _____
 Other known allergies: Nickel/metals Flowers/trees/grasses Fragrances Latex (type I)
 Rubber Medicines Insects Animals Other _____
 Suspected allergies: _____
 Previous drug reactions: No Yes: drug(s), date(s): _____

Family history of allergies and asthma: Yes No Hay fever: Yes No Eczema: Yes No
 Relationship (name): _____ Allergy: _____
 Relationship (name): _____ Allergy: _____

Home Environment: House Apartment/Condo Constructed after 1980: Yes No
 Renovated since 1980: Yes No Location: Suburban Urban Rural Other: _____
 Duration of residence: _____
 Frequency of housecleaning: Daily Weekly Monthly Occasional
 Participates in housecleaning: No Yes, always Yes, sometimes Rarely
 Does laundry: No Yes, daily Yes, weekly Yes, sometimes
 Equipment/Materials used: _____ Detergents: _____

Pets/Animals: None Cats Dogs Birds Rodents
 Livestock: _____ Other _____
 Pets/animals as a child: No Yes: _____ Regular contact: Yes No
 Recent animal contact: No Yes: _____ Pets in house: Yes No
 Symptoms noticed at home or around animals: _____

Sports/Hobbies: Golf Skiing Baseball Running/hiking Tennis/raquetball
 Basketball Football Sewing Paper crafts Home repairs Knitting/needlework
 Ceramics Guitar Piano Painting Computers Woodworking
 Other instruments: _____ Photography Other _____
 Frequency: Daily Weekly Monthly Once a year Rarely
 Duration: _____ Equipment/Materials used: _____

Symptoms noticed in sports/hobbies: _____

Personal Care Product Frequency of Use and Type or Brand:

Symptoms noticed with personal care: _____
 Handwashing : _____ Soap: _____
 Bathing : _____ Soap: _____
 Lotion : _____ Creme: _____
 Deodorant : _____ Body wash : _____
 Perfume : _____ Aftershave: _____
 Shaving cream : _____ Hair coloring: _____
 Toothpaste : _____ Mouthwash: _____
 Shampoo : _____ Conditioner: _____
 Hair styling aids: _____ Nail polish: _____

Other personal care products: _____

Wears Makeup: Blush Mascara Face powder Eyelid powder/liner
 Foundation/base Remover Concealer Lipstick/gloss/liner Moisturizer/cream
 Toner/astringent Masque Cleanser Other: _____

Contact lenses: Saline _____ Lens cleaner(s): _____

Jewelry: Wear daily Wear weekends Wear seldom Wear special occasions
Type: Rings Watch Bracelet(s) Earrings Piercing(s) Necklace(s)
Metals: Gold Sterling Stainless steel Platinum Nickel plated Other _____

Tatoos: New Old Permanent Temporary Henna-based

Use Condoms/diaphragms: Daily Weekly Monthly Occasionally
Type: _____

Employment History: Current employer: _____ Since (date): _____
Job title: _____ Since (date): _____

Job description: _____

Same employer at onset of dermatitis: Yes No; employer at onset: _____

Previous job description and duration: _____

Regular contact: Metals Dust Fibers Fluids Vibration/cold/heat
 Solvents Fumes Chemicals Other: _____
 Rarely Daily Weekly Monthly Other: _____

Describe work site: Factory Office Hospital Laboratory Construction
 Agriculture Indoors Outdoors Other _____

Work Equipment: Gloves Boots Face shield Apron Mask/respirator
 Overalls Badge Head covering Monitors Other _____

Symptoms at work: _____ Since (date): _____

Description of work when symptoms began: _____

Materials associated with this work: _____

Treatment/ Documentation at place of employment: _____

Effect of weekends/holidays/vacations: Improved No change Worse

Loss of work: No Yes, on dates: _____ Other workers with same problem No Yes

Previous compensation claims: No Yes, for _____

Second job: Full time Part-time Yes, as: _____

Job description: _____

Describe work site: Factory Office Hospital Laboratory Construction
 Agriculture Indoors Outdoors Other _____

Symptoms at 2nd job: same different: _____ Since (date): _____

Notes: _____