DERMATITIS QUESTIONNAIRE

INSTRUCTIONS: Carefully complete <u>all four sides</u>. Any item unmarked is considered a negative response to the question. Relate your answers to your own experiences, not to previous advice or skin tests. ALL INFORMATION WILL BE CONSIDERED CONFIDENTIAL.

____

Name Age Sex Race / Ethnicity

Florida Primary Care Dr._______________________

Referring Dr. _______________________

Dermatologists you have seen for this condition: _______________________

Preferred Local Pharmacy (Phone & Street Name)_______________________

What is your **chief complaint?**_______________________

When did it **first begin** _________ (year) Recent **flare-up** __________ (month) __________ (year)

Circle as many terms as seem to describe your problem:

____ ***RASH Alone*** ____ ***ITCH Alone*** ____ ***BOTH*** ____ ***NEITHER***

Size (circle): Pinpoint, dime, quarter, silver dollar, baseball, giant

Color (circle): Pale, pink, red, blue, red edges with pale center, Brown

Character (circle): Itchy, burn, tender to touch, stinging, prickling, tingling, hot, pain, crawling feeling

Form (circle): Raised, swollen, blisters, scaling, thickened skin, flat and red

Area of body affected (circle): Scalp, face, mouth, throat, shoulders, arms, armpits, elbows, palms, fingers, chest, back, abdomen, groin, buttocks, legs, knees, soles, between toes, all over body.

Area rash was **first seen:** _______________________

____ ***SWELLING***

Circle **areas which swell**: Ears, eyelids, lips, tongue, throat, hands, feet, joints ....

Other: _______________________ ____None

____ ***MISCELLANEOUS*** other symptoms (circle): Joint pain, nausea, vomiting, diarrhea, stomach cramps ____None

IN GENERAL ....

Timing of occurrences (circle): Daily, weekdays, weekends

Worst time of the day (circle): Morning, afternoon, evening, middle of the night, anytime

Worst time of the year (circle): January, February, March, April, May, June, July, August, September, October, November, December ____All ____None

When does your problem flare up (circle): at home, work, school, vacation, sports, hobbies........

Other_______________________ ____None

Does **anyone else at home** have a similar problem? _______________________ ____None

How long does **each lesion** last? ____ few minutes ____ less than 24 hours ____ more than 24 hours ____ constant

Is your condition **worsened** by (circle): Sunlight, hot water, cold water, sweating, vibration, exercise, swimming, pressure, rubbing, emotional upset, air drafts ____None

Do any of the following **foods cause you symptoms** of any sort (circle): Alcohol, beer, wine, milk, cheese, chocolate, eggs, fish, shellfish, nuts, peanuts, citrus, tomatoes, wheat, corn, strawberries, spices, MSG, chemical preservatives ____None

Do you use **tartar control**: ___ toothpaste ___ gel ___mouthwash ___ other teeth whiteners ____None

PRESENT ILLNESS and REVIEW OF SYMPTOMS

Please fill in **trade names of products** you currently use:

toothpaste/gel:________ → Tartar control: yes / no		moisturizer:________	____None
mouthwash:________ → Tartar control: yes / no		perfume / aftershave:________	____None
denture products:	____None	cosmetics:________	____None
facial soap/cleanser:________	____None	sachet:________	____None
bath soap:________	____None	detergents:________	____None
shampoo:________	____None	powdered bleach:________	____None
rinse/conditioner:________	____None	fabric softener:________	____None
hair dye:________	____None	anti-static dryer sheets:________	____None
hair spray / gel:________	____None	insect repellents:________	____None
deodorant:________	____None	suntan lotion/sun block:________	____None

Any **recent exposure** to (circle): Odors, smoke, aerosol products, fertilizer, paint, chemicals, talc, hot tub use, latex or rubber gloves, other:________ ____None

Have you been exposed to flea collars, flea sprays, powders or dips? Yes___ No___

Have you **traveled outside of the USA** in the last two years? Yes ___ No ___ Where: ________

Have you been exposed to anyone with **hepatitis** in the last year? Yes ___ No ___ When: ________

Have you ever had a **blood transfusion?** Yes___ No___ When: ________

Do you consider yourself (circle): High strung, under stress or tension, cry easily, depressed, worrier, hard-driving, perfectionist, compulsive, easily excitable, always tired, lack of energy, other:________ ____None

Do you experience any of the following (circle): Trouble getting to sleep, restless sleep, awaken with a startle, awaken early, financial problems, health problems, problems at work or school, sexual problems .... ____None
If patient is a child ... emotional impact of: ____parental discord ____sibling problems ____None

Marital or family problems: Afraid for your safety ...the children's safety ...verbal abuse ...physical abuse ____None

Is there any **coincidence between your symptoms** and (circle): puberty, menses, premenstrual, menopause, use of hormones, birth control pills or other barrier devices (condoms, diaphragms, spermicidal agents, etc), intercourse, pregnancy ____None

List your present and pre-retirement **occupation(s)**: ________

Occupational exposure: Stress, tension, odors, dusts, smoke, fumes, talc, chemical mists/sprays, fiberglass, solvents, animals, moldy hay, silos, barns, sugar cane, extremes of temperature or humidity, latex gloves, strong soaps ____None

Circle other problems you have experienced ...

High blood pressure	Earaches	Cough	Heartburn
Chills / fever	Sore throat	Hoarseness	Nausea/vomiting
Feel faint	Swollen glands	Chest pain	Cramps/diarrhea
Dizziness	Stuffy/runny nose	Bronchitis/asthma	Vaginal discharge/itch
Gum disease	Sinus problems	Breast cysts	Burning urination
Glaucoma	Post nasal drip	Gallbladder problems	Nail/foot fungus
Itchy eyes	Sneezing	Night sweats	Joint aches and pains
Earaches	Hoarseness	Cramps/diarrhea	Insomnia ____None

PAST MEDICAL/SURGICAL, SOCIAL AND FAMILY HISTORIES

Childhood: Breast fed, bottle fed, colic, croup, hives, eczema, frequent colds, recurrent earaches, tonsillitis, asthma, bronchitis, food allergies, headaches, hyperactive, learning disability, other:________________

Medical conditions **for which you've ever had**: diabetes, high blood pressure, stroke, heart condition, hiatal hernia, gerd/reflux, TB, pneumonia, COPD, hypothyroid, hashimotos, arthritis, glaucoma, cancer, HAE, immunodeficiency, hypoglycemia, sleep apnea, anxiety, depression, osteoporosis, learning disability, **other:**________________________

Surgeries & Year performed: ____ _____None

Drug Allergy & Reaction: Penicillin, Erythromycin, Sulfa, Aspirin, Iodide, X-Ray dye, Novocain, Codeine
Other:____ _____None

Medications/Supplements current: ____

CPAP: yes no / **Oxygen:** yes no

Last ***Flu shot:***________________(mo/yr) Last ***Pneumonia shot***________________*(mo/yr)*
Last Labs:_____(mo/yr) with Dr.____________ **Last CT:** sinus/chest______(mo/yr) with Dr.____________
Last **Cxr:**_____(mo/yr) with Dr.____________ Last **skin biopsy** _______mo/yr) with Dr.____________

Drug Usage: Marijuana, heroin, cocaine, body building steroids, recreational drugs ***How often?***_________ _____None
Menses: Last period:__________(Date) Are you ***pregnant?*** Yes / No
Tobacco: (circle) Cigarettes, cigars, pipe ***Still Smoke:*** Yes / No ***Inhale:*** Yes / No
Number per day _____ ***Year started***_____ ***Year stopped*** ______ ***How many years***______ _____Never
Are you ***exposed to smoke:*** ___ at home ___ at work ___ socially

Marital Status: (give parents' status if patient is a child)
Married, re-married, single, cohabitating, separated, divorced, widowed, gay / lesbian
Number of children: _______ Any adopted: ___ yes ___ no
If patient is child: ___ One residence ____ Time split between two parent's homes
Education level:________________________
Alcohol Intake: Average per day _____ Type: ____Liquor _____ Beer ____Wine _____None

Hobbies:____

Family Illnesses	*Self*	*Father*	*Mother*	*Brothers*	*Sisters*	*Children*	*Grand-parents*
Migraine							
Hives							
Eczema							
Hay Fever							
Sinus Condition							
Glaucoma							
Emphysema							
Asthma							
Cystic Fibrosis							
Tuberculosis							
Diabetes							
Thyroid Disease							
Heart Attack							
Stroke							
High Blood Pressure							
Cancer							
Other							

Attn. Coding Auditor: As per E/M guidelines, any items left uncircled, unchecked, or blank indicate a pertinent negative entry.___None

ENVIRONMENTAL and ALLERGY HISTORIES

How long have you lived ***in this area of Florida*** ______(years)
If a part-time resident, where is your ***other home*** (state/country) ________________________

Type of Dwelling → Condo, apartment, cement block house, wood house, dormitory, mobile home, boat
Fla home: ***Year Dwelling built:*** _______ ***Move in year:***__________
Out of state home: ***Year Dwelling built:*** _______ ***Move in year:***__________

HOW MANY OF EACH PET DO YOU HAVE:__Dogs, __Cats, __Birds, __Hamsters, __Rabbits, __Gerbils, __Guinea pigs, __Horses ___None My pets come: ___indoors ___strictly outdoor pets
Does your pet have **fleas**: Yes___ No___ Has pet had **mites**? Yes___ No___

	Fla.home	OOS home	
Pillow: Feather, foam, dacron / polyester,	_____	_____	(year purchased)
Mattress: Foam, inner spring, waterbed, air mattress, sleep number	_____	_____	(year purchased)
Mattress Topper / Bedpad: Feather, foam, dacron / polyester	_____	_____	(year purchased)
Blanket: Cotton, polyester, wool, feather comforter	_____	_____	(year purchased)
Flooring: Carpeting in: ___ ***Bedroom*** ___ ***Livingroom***	_____	_____	(year purchased)

A/C: ***Central Air*** ___yes ___no ***Wall unit*** ___yes ___no
Ceiling fans: ___ yes ___no

<u>Previous Allergy Evaluation:</u> When: ______________ (approximate year)
Allergist's name and city: ________________________
Allergies discovered at that time:________________________

Are you ***now*** receiving ***allergy injections***? Yes / No Ever had an ***adverse reaction to allergy shots***? Yes / No
Injection contents ________________________
When was your ***last injection***? ______________ ***How long*** have you been receiving them? _______ (years)
Miscellaneous:
Have you ever had ***collagen, silicone implants*** or ***metal joint*** parts surgically placed in your body? _____None
Where in body / When: ________________________

Insect bites or stings: Large local swelling, itching all over body, rash all over body, weakness, sweating, shortness of breath, stuffy nose, wheezing, swollen eyes _____None

PATIENT SIGNATURE:________________________

<u>PHYSICIAN'S ANALYSIS OF DATA:</u>

Dr. Signature:________________________ Med Asst. Initials________ Date:______________

Attn. Coding Auditor: As per E/M guidelines, any items left encircled, unchecked, or blank indicate a pertinent negative entry. ©J&J Tandem, Inc. 4/2019