

# 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

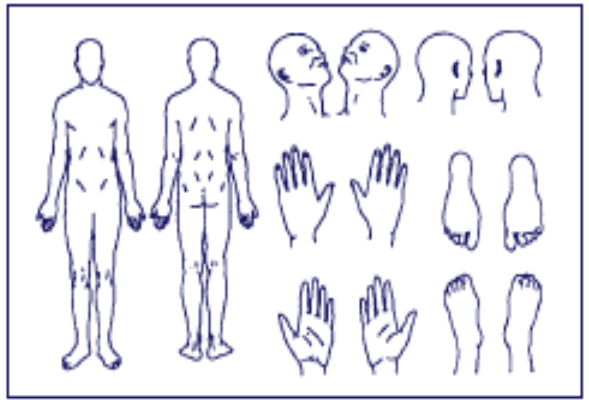
Currently:  Stable  Increasing  Decreasing

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 2<sup>nd</sup> job:    same    different: \_\_\_\_\_ Since (date): \_\_\_\_\_

**Notes:** \_\_\_\_\_