ASTHMA & ALLERGY CENTER

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Asthmaweb.com
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Contact Dermatitis Questionnaire

Patient's Name: _____ DOB:_____

How long have you had the rash?		**This Column is For Physician's Use**
Where on your body did the rash appear first?		
Describe your symptoms:		
Does the rash ITCH, OOZE or CRUST? (Now or in the past)		
List any Fumes, chemicals at home or work, cosmetics, meds, foods, Places or Situations that you suspect make your rash worse.		
List current medications you are using for the rash		
List prior medications you have used for the rash:		
What is your occupation?		
Do you think this rash is related to your job?	If yes, please elaborate:	
Have you had prior skin diseases?	If yes, please elaborate:	
Any personal history of asthma, hay fever, eczema?	If yes, please elaborate:	
Any history of sensitivity to cosmetics, sunscreens, jewelry, poison oak/ivy?	Yes / No / Not sure If yes, please elaborate:	
Have you had Allergy Tests before?		
List all the products you use for face (i.e. lotions, cleansers, make-up, shaving etc.		
List all products you use for body/hands (i.e. soaps, lotions, cleansers, make-up, etc.		
List the products you use for nails, hair (i.e. dye, bleach, perm, etc.)		

Date: _____ _____MD / PA-C