

PATIENT PLEASE COMPLETE FORM

Name _____ Date _____

Skin Rashes

Describe skin rash: _____
Color _____ Location _____ Bruising _____
Duration of individual lesions _____ Frequency _____
Severity _____ Does it itch? _____
Swelling of (circle): Eyelids Lips/Mouth Throat Other None
Other symptoms _____

Circle if you have had rash with exposure to: Metal/jewelry Poison ivy/oak/sumac Other _____

If you use the following, **please state** **brand**

- | | |
|-------------------|----------------------------|
| Cold pills _____ | Meat tenderizer _____ |
| Aspirin _____ | Soft drinks _____ |
| BC pills _____ | Chewing gum _____ |
| Antacids _____ | Artificial sweetener _____ |
| Vitamins _____ | Breath spray _____ |
| Laxatives _____ | Cough drops _____ |
| Toothpaste _____ | Bath soap _____ |
| Mouthwash _____ | Detergent _____ |
| Shave cream _____ | Bleach _____ |
| After shave _____ | Fabric softener _____ |
| Hair spray _____ | Pre-soak _____ |
| Shampoo _____ | Air freshener _____ |
| Hair rinse _____ | House cleaner/spray _____ |

CIRCLE IF YOU HAVE HAD RECENT HISTORY OF:

INFECTIONS:

Recurrent colds / Sore throats / Chest problems / Dental problems / Sinus disease / Athlete's foot
Heartburn / Vaginitis / Kidney problems / Bladder infections / Gallbladder disease / Hepatitis / None

PARASITIC DISEASE:

Travel outside USA / Pin worms / None

PSYCHOLOGICAL FACTORS:

Nervous tension / Family strains / Job/School Stress / Marital Stress / Child Related Stress / None

HEREDITARY:

Family history of hives / History of Respiratory distress / GI symptoms / None

PHYSICAL:

Development or increase in hives with: Exercise / Heat / Light / Cold / Pressure / Water / None

CONNECTIVE TISSUE DISEASE:

Arthritis / Joint Problems / None

PHYSICIAN OR NURSE COMPLETE THIS PORTION:

MODIFYING FACTORS:

On β blocker / Urticaria pigmentosa / Systemic mastocytosis / Diabetes / Thyroid disease / Primary biliary cirrhosis / None