Skin Rash

Patient Name: _____ **Date:** _____

Describe skin rash: _____

Color: _____ Location: _____ Bruising: _____

Duration of individual lesions: _____ Frequency: _____

Severity of rash: _____ 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 the <u>brand</u>:

Cold pills _____
Aspririn _____
BC pills _____
Antacids _____
Vitamins _____
Laxatives _____
Toothpaste _____
Mouthwash _____
Shave cream _____
After shave _____
Hair spray _____
Shampoo _____
Hair rinse _____

Meat tenderizer _____
Soft drinks _____
Chewing gum _____
Artificial sweetener _____
Breath spray _____
Cough drops _____
Bath soap _____
Detergent _____
Bleach _____
Fabric softener _____
Pre-soak _____
Air freshener _____
House cleaner/spray _____

Circle if you have had RECENT history of:

INFECTIONS

Recurrent colds Sore throats Chest problems Dental problems Sinus disease Heartburn

Athlete's foot Vaginitis Kidney problems Bladder infections Gallbladder disease None

PARASITIC DISEASE

Travel outside USA Pin worms None

PSYCHOLOGICAL FACTORS

Nervous tension Family strains Job/school stress Marital stress Child related stress None

HEREDITY

Family history of hives History of respiratory distress GI symptoms None

PHYSICAL

Development or increase in hives with: Exercise Heath 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 Primary biliary cirrhosis Systemic mastocytosis

Thyroid disease Diabetes None

11-08 (SkinR)

Grand Rapids Allergy 970 Parchment Drive SE Grand Rapids, MI 49546 Phone: (616) 949-4840 Fax: (616) 949-3531 www.grandrapidsallergy.com