

Skin Rash



Patient Name: _____ **DOB:** _____ **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 _____

Have you made changes in any of the following: (Circle)

Personal care products

Mouth wash Toothpaste Breath Spray Shaving items Deodorant Hair care items Cosmetics Bath soap

OTC meds/Supplements/Prescription medications

Antacids Vitamins Laxatives BC pills

Cold and flu products

Cold pills cough drops Aspirin

Laundry products

Detergent Pre-soak Fabric softener Bleach Dryer sheets

Cleaning products

Shower sprays Carpet cleaners Dusting products

Ingested items

Meat tenderizer Soft drinks Chewing gum Artificial sweetener

Circle if you have had RECENT history of:

Infections

Recurrent colds Sore throats Chest Dental Sinus Athlete's foot

Vaginitis Prostatitis Kidney Bladder Gallbladder disease None

Parasitic Disease

Travel outside USA Pin worms None

Physical

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

Provider or nurse complete this portion. Modifying factors:

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

5-11(Skinrash)