Oregon Dermatology and Research Center
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Psoriasis History Sheet

Please help us be thorough in the treatment of your psoriasis by answering the following questions:

Name: _____ Age: _____ Sex: M or F Date: _____

Have you ever been diagnosed with psoriasis by a physician? YES ☐ NO ☐
If yes, what was your approximate date of diagnosis? _____

Locations of current psoriasis (circle all that apply):
Hands Feet Face Scalp Trunk Arms Legs Genitals Nails

What are your symptoms (i.e. dryness, redness, pain, itching)?

_____

_____

Do you have joint pain? YES ☐ NO ☐
If yes, where do you have the joint pain?

_____

Does your body feel stiff when you wake up? YES ☐ NO ☐
Have you ever been diagnosed with psoriatic arthritis? YES ☐ NO ☐

Does your psoriasis affect your job or personal life? YES ☐ NO ☐
If yes, please explain:

_____

_____

_____

What treatment are you currently using for your psoriasis/psoriatic arthritis? Please include frequency and duration of treatments.

_____

_____

_____

What treatments have you tried in the past for your psoriasis/psoriatic arthritis? Please include frequency and durations of treatments, and any side effects or reason for discontinuation.

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