

# Phoebe Rich Dermatology

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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)?

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Do you have joint pain? YES NO

If yes, where do you have the joint pain?

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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:

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

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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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