Dr. Sheth Psoriasis Questionaire - GHA

Today's Date _____ **Patient Name** _____ **DOB** _____

Name of referring doctor : _____ **Best Contact Phone number :** _____

Psoriasis HISTORY

1. How long have you had psoriasis? _____ Did it worsen recently (when)? _____
2. What parts of the body are involved? (Please circle)

   Scalp Face Ears Neck Torso Arms Legs Palms Soles Buttocks Genitals Nails
3. Psoriasis causes: (Please circle) Itching Pain Bleeding No symptoms Other _____
4. Things that effect your psoriasis are: Please circle Sun Stress Medications Other _____
5. What is the worse thing about your psoriasis? _____
6. On a scale of 1 to 10 (1 being little effect, and 10 being severe effect on daily life) how would you rate the impact of the psoriasis on your life? _____
7. Does the psoriasis affect your occupation (is yes, how) ? _____

MEDICATIONS

8. What medicines are you currently using for your psoriasis? _____
9. List all other medications you are currently on? _____

10. **Please circle** all psoriasis treatments you've tried and **write in what month/year** you tried them:

Dates	Topical Treatments	Dates	Systemic Treatments	Dates	Biologic Agents
_____	←Topical Steroids	_____ to _____	←Soriatane (Acitretin)	____ to ____	←Amevive
	(eg. Hydrocortisone,	_____ to _____	←Tegison (Etretinate)	____ to ____	←Raptiva
	Triamcinolone,	_____ to _____	←Cyclosporine (Neoral)	____ to ____	←Enbrel
	Fluocinonide,	_____ to _____	←Methotrexate	____ to ____	←Remicade
	Betamethasone,	_____ to _____	←Oxsoralen (PUVA)	____ to ____	←Humira
	Clobetasol, etc.)	_____ to _____	←Phototherapy		
_____	←Steroid shots into skin	_____ to _____	←Broadband UVB		
_____	←Dovonex	_____ to _____	←Narrowband UVB		**Study drugs**:
_____	←Tar preparations (LCD or	_____ to _____	←Tanning Beds		
	crude tar)	_____ to _____	←Thioguanine	____ to ____	←IL-12
_____	←Tazorac	_____ to _____	←Prednisone	____ to ____	←Adalimumab
_____	←Derma-Smoothe scalp oil	_____ to _____	←Oral or injected steroids	____ to ____	←Tazoratene
_____	←Tar shampoo				

TREATMENT ISSUES

Occupation (and location of work or school) _____ Area of residence? _____

If phototherapy is recommended, how convenient is the Clifton or Kenwood office for you? (Please circle)

Very convenient Moderately convenient Slightly convenient Not convenient

Patient Name _____ **DOB** _____

REVIEW OF SYSTEMS

Do you have **medication allergies** (if yes, please indicate drug name and type of reaction): _____

11. Please circle if you are currently having problems with any of the following:

Fevers	Muscle aches
Fatigue	Joint aches or swelling (which joints? _____)
Blurred vision	Tingling or numbness
Difficulty swallowing	Uncontrolled weight gain or loss
Shortness of breath	Heart/Chest pain
Stomach or bowel problems	Allergies
Bladder problems	Blood diseases
Leg swelling	Swollen lymph nodes

PAST MEDICAL/SURGICAL HISTORY :

12. Please circle if **you** specifically have a history of any of the following:

    high cholesterol, liver disease, hepatitis, alcohol abuse, kidney disease, depression, tuberculosis, cancer, skin cancer, eye disease, anemia, chronic headaches, HIV infection, psoriatic arthritis

13. Please list any other medical problems or surgeries you have had or are scheduled for:
    _____

14. Do you currently have any active infections? _____
15. Have you had the Hepatitis-B vaccine? _____ If yes, when? _____
16. Have you had a tuberculosis test done in the last year? _____ If yes, where? _____
17. Do you have any medication allergies? (If yes, please indicate drug name and type of reaction): _____
    _____
18. Do you drink alcohol? _____ If yes, how much? _____ Do you smoke? _____ How much? _____

FAMILY HISTORY:

19. Please circle if there is a family history of: psoriasis, depression, multiple sclerosis, cancer, psoriatic arthritis.
20. Please list any family history of skin problems, skin cancer or melanoma: _____
    _____
21. Please list any major medical problems in your immediate family: _____
22. Are you planning on having children? Please circle Yes No If yes, when _____
23. If sexually active what would be your choice of contraception?_____

_____ _____ _____ _____
Patient (or Guardian) Signature Date Reviewed by: Pranav Sheth, M.D. Date