



21785 Filigree Court, Suite 206, Ashburn, VA 20147
(703) 996-4000 www.ClearDermVA.com

Rash Patient: Name _____ DOB _____

How long has the rash been active? _____ Days _____ Weeks _____ Months _____ Years
Where did the rash start and has it spread? _____

Is the rash itchy? No Mildly Moderately Severely Has severe moments but otherwise mild
Is the rash painful? No Mild burn, sting Moderate burn, sting Severe burn, sting
Other symptoms: _____

Do you have pets in the house? YES NO If yes, type of pet: _____
Do you have frequent and prolonged exposure to small children (under 13)? YES NO
Do you wrestle or perform any other close contact sports? YES NO
Do you swim regularly? YES NO
Any recent travel? YES NO If yes, to where: _____
Any recent colds or runny noses with or without fever? YES NO Any sore throat? YES NO
What do you do for a living? _____

What hobbies do you have (gardening/cooking/woodwork, etc)? _____

What over the counter medications do you take, if any? _____
What supplements do you take, if any? _____
If yes, how often do you moisturize? _____ time(s) a day once in a while
How many times do you wash your hands with soap in a day? _____ times a day
Do you use plug ins, scented candles, etc. in your house or your car? YES NO
Do you have history of sensitive skin? YES NO
Family history of sensitive skin? YES NO

Name the products you use for the following:

- Moisturizer face: _____
- Moisturizer body: _____
- Shampoo: _____
- Conditioner: _____
- Soap: _____
- Shaving cream/gel: _____
- Toothpaste: _____
- Mouthwash: _____
- Hand wash: _____
- Make up: _____
- Nail polish: _____
- Hair dye: _____
- Clothing detergent: _____
- Other: _____



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