Clear Dermatology

22365 Broderick Drive Sterling, VA 20166
(703) 996-4000 www.ClearDermVA.com

## Rash Patient:

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: _____
What have you treated your rash with so far? _____
_____
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? _____
Do you moisturize? YES / NO
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: _____