SKIN PATIENT CARD.

YOUR NAME____

ADDRESS:____

POSTCODE:__________________ MARITAL STATUS:_________NO. OF CHILDREN:_________________

SEX: M /F________ OCCUPATION:_________________________________

BIRTHDATE:___________________PLACE OF BIRTH:________________HOME PHONE :______________

WORK/mobile PHONE:______________________________Email address :_____________________________

_Would you like to be kept informed of new products and changes to this practice _________________________

How did you hear about the Psoriasis & Acne Clinic ?____________________________________

What body area/s are affected by your skin condition ? ____

____ __________________________ ____ _ _____

Is the condition itchy ?____

Does your skin condition flare up often ?____________________________________

Circle any medication that you have taken in the past or are currently taking
estrogen progesterone contraceptive pill Hydroxyurea **ANTIHISTAMINES** aspirin naprosan sulfasalazine (Indocin) cyclosporine Methotrexate TEGRISON **topical cortisone creams** (Inderal ,Elecon, Diprosone) GOLD LITHIUM ANTIMALARIA antifungals(Lamosil)Terbinafine TETRACYCLINES, CAPTOPRIL, CHLORTHALIDONE, GEMFIBROZIL Beta blockers Indomethacin

PLEASE LIST ANY OTHER MEDICATIONS:

____

CONDITION YOU WERE/ARE BEING TREATED FOR ____

Circle any previous treatments PUVA Skin biopsy Allergy testing

Have you previously consulted with a 1. GP 2. Dermatologist 3.beauty therapist

When did your skin condition first appear ? Age 1-15 years 16 -22 years old 30-50 years

Does any of the following aggravates your condition ? 1. Some foods 2. Weather wet or dry 3. Seasonal winter or summer 4.Temperature hot or cold 5. Morning or evening 6.Different types of clothing 7. other________________

Do you have (or have had) **contact with any household or farm animals ?**____________________________

Please tick any of the following symptoms you may be experiencing

Emotional/ mental status	__ *angry*
__ anxiety	___suicidal tendency
__ changeable moods	___slow comprehension
__ crying moods	___sighing
__depressing moods	___screaming
__despairs getting well	___sadness
__difficult thoughts,dread ,nervousness	___passionate outbursts
__forgetful	___over sensitive
__fretful	___ night terrors
___hallucinations	___indifference
___indecisions	____fearful

_ loose stool where the stool contains abnormal amounts of fat	
___Nausea	_____vomiting
——gall bladder trouble or pain under right ribcage	_____feel sick when cooking oily, fatty foods
____asthma	____Inflammation of the eye
_____eye pain	_____conjunctivitis.
____sore throat or *strep throat*	
_____ insomnia ie trouble getting or staying asleep	

please continue over the page

Skin	___palpitations	***Healthy History-Have you or a family member had any of the following conditions*** —— please tick	
___boils	___always cold hands & feet	diabetes	psoriasis
___rashes	_____swelling of ankles	epilepsy	polio
___dryness	____dizziness	goiter or thyroid problem	cancer
___itching	_____difficulty breathing after small effort	M.S.	pneumonia
___excema or dematitis	_____feeling cold and often a bit sick/uncomfortable	measles	pleurisy
___psoriasis	____high or low blood pressure	mumps	emphysema
___pigmentation Lighter	***Females only***	Tuberculosis	a history of miscarriage
___pigmentation darker	____hot flushes or night sweats	maleria	allergies to foods
___excess oiliness	____irregular cycle	stroke	allergies environmental
___skin type normal	____menopausal symptoms	typhoid or rheumatic fever	arthritis
___skin type oily	____PMT symptoms		
___skin type dry	Are you pregnant? Y /N_______		

_____tinea	___wine color under nail	___itchy scalp
_____foot odor unpleasant	____dandruff	___scalp oiliness
_____swollen feet	____Falling out of hair	____scalp dry
_____nail with pits	___lumps on scalp	____seborrhea
__separate from its nail bed	___soreness to touch	____arthritic joints

How many glasses of water do you drink daily ?	**Do you smoke?** yes/no	**Do you exercise regularly?**	
Are you exposed to any of the following Chemicals ?	♦ oil based paints/laquers/ thinners ♦ insecticides/herbicides	♦ to hair dyes/perming agents	♦ chlorine in swimming pools or drinking water
Are you agitated or irritable when you wake up in the morning or before meals and then feel better after eating ?	Do you suffer from hay fever, migraine headaches ,rheumatoid arthritis or allergies ?	Any other symptoms not already listed ?	Ie menopause Lower back pain

Thank you for filling out this medical record.Please signature that the above is correct.

Your signature here ____

We would like to ask you to allow us to use your photos very discreetly so others may view the results of our treatment. No names are used . Only before and after photos. Please discuss this with your consultant.

Date :

Initial indications — Tongue :

Nail :

Other:

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