**NEW Problem**

(Not previously addressed by Dr. Vennos)

Questionnaire

Patient Name

 Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Directions:

1. Please complete this form if you have a skin condition. For example: a rash or rash-like area(s), acne or possible skin infection. Do not use this form for simple spots, lesions, moles, etc. (no questionnaire necessary)
2. **ONE** skin problem per form. (Use additional forms, if more than one problem.)
3. **Fill in every blank**.

|  |  |  |
| --- | --- | --- |
| **Describe** your problem(E.g., rash, spots, bumps, etc) |  | Office Use Only |
| **Location** of problem(E.g., back, face, arms, legs) |  |  |
| **Date** problem first ever started | Month \_\_\_\_\_Day \_\_\_\_\_Year \_\_\_\_\_\_ |  |
| **Have any tests** done for this problem? (E.g., a skin sample, blood tests, etc.) | * Yes, result
* No
 |  |
| **Feel** of skin problem (E.g., itch, sore, rough, burning)  | * Feels normal
 |  |
| **Look** of skin problemE.g., color, shape | * Looks normal
 |  |
| Has problem ever gone away? | * No
* Yes, when:
 |  |
| Name brand of **soap (s) or shampoo** used on problem area | * No soap ever used
 |  |
| Name brand of **moisturizer (s)**usedon problem areas | * No moisturizer ever used
 |  |

Continued

**Anything else** you want the doctor to know about **this** problem:

**List ALL Treatments**

**List all Treatments and Products**

**Current and prior for this skin problem only.**

* I have had NO treatments of any kind for this problem.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **NAME** of each productInclude:* Prescriptions
* Over-the-counter
* Any other treatment
 | **TYPE** of product E.g.:* pill
* cream
* ointment
* gel
* liquid
* cleanser
 | Date**FIRST**used? | Date**LAST**used? | **HOW OFTEN**used or applied?Eg.DailyWeekly | Office Use |
| **1.** |  |  |  |  |  |
| **2.** |  |  |  |  |  |
| **3.** |  |  |  |  |  |
| **4.** |  |  |  |  |  |
| **5.** |  |  |  |  |  |
| **6.** |  |  |  |  |  |
| **7.** |  |  |  |  |  |
| **8.** |  |  |  |  |  |
| **9.** |  |  |  |  |  |
| **10.** |  |  |  |  |  |
| **11.** |  |  |  |  |  |
| **12.** |  |  |  |  |  |
| **13.** |  |  |  |  |  |
| **14.** |  |  |  |  |  |
| **15.** |  |  |  |  |  |

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