Oregon Dermatology and Research Center
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Psoriasis History Sheet

Please help us be thorough in the treatment of your psoriasis by answering the following questions:

Name: ____________________________ Age: ______ Sex: M or F Date: __________

Have you ever been diagnosed with psoriasis by a physician? Circle one: YES NO
If yes, what was your approximate date of diagnosis? ___________

Locations of current psoriasis (circle all that apply): hands feet face scalp trunk arms legs genitals nails
What are your symptoms (i.e. dryness, redness, pain, itching)?
____

Do you have joint pain? Circle one: YES NO
If yes, where do you have the joint pain?
____
Does your body feel stiff when you wake up? Circle one: YES NO
Have you ever been diagnosed with psoriatic arthritis? Circle one: YES NO

Does your psoriasis affect your job or personal life? Circle one: YES NO
If yes, please explain:
____
____
____
What treatment are you currently using for your psoriasis/psoriatic arthritis? Please include frequency and duration of treatments.
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____
What treatments have you tried in the past for your psoriasis/psoriatic arthritis? Please include frequency and durations of treatments, and any side effects or reason for discontinuation.
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