Dermatology of the Berkshires pc

VICTORIA R. CAVALLI, M.D. BOARD CERTIFIED DERMATOLOGIST

RASH PATIENT INFORMATION SHEET

Name:____ DOB: _______________________ Date: ___________

When and where did the rash start? ____

Please list involved areas (scalp, face, neck, chest, abdomen, back, arms, hands, legs, feet, buttocks, genital area): ____

____

Is the rash itchy or painful? ____

Is the rash disrupting your sleep? ____

Have you had this rash (or a similar one) before? ____

If yes, is the rash seasonal? ____

Please list any triggers or exposures: ____

____

What makes the rash better? ____

What makes the rash worse? ____

Does anyone else in your household have a similar rash? ____

Do you have any pets at home? ____

Please list medications or treatments you or your doctor tried (either prescription or over-the-counter pills or creams): ____

____