Dermatology of the Berkshires pc
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**ROSACEA PATIENT INFORMATION SHEET**

Name:_____ DOB: _____ Date: _____

When did symptoms start? _____

Please list involved areas (face, neck, chest, back, shoulders): _____

_____

Have you noticed redness or flushing, broken blood vessels, red bumps, pus bumps, pimples or other symptoms? _____

What makes it better? _____

What makes it worse? _____

For women, do symptoms vary with your cycle? _____

Would you describe your skin as normal, oily, dry or sensitive? _____

What is your daily skin care regimen? Please be specific about cleansers, moisturizers, sunscreens and anti-aging products. _____

_____

_____

Have you previously been treated for rosacea? _____

Please list prior prescriptions and duration of use (i.e., MetroGel, Noritate, sulfacetamide, Plexion, Finacea).

_____

_____

Are there any skin care products or ingredients you can not tolerate? _____

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