

Follow-up Psoriasis

Name _____ Birth Date _____ Date _____ Page _____

How do you feel, in general, today? 1= worst imaginable 10 = glorious _____

Psoriasis compared to last visit: much worse worse same better much better gone

How is psoriasis affecting your life?(1=minor annoyance 10=ruining my life) _____

What is the worst part of your psoriasis? _____

Know anything which may have worsened your psoriasis? _____

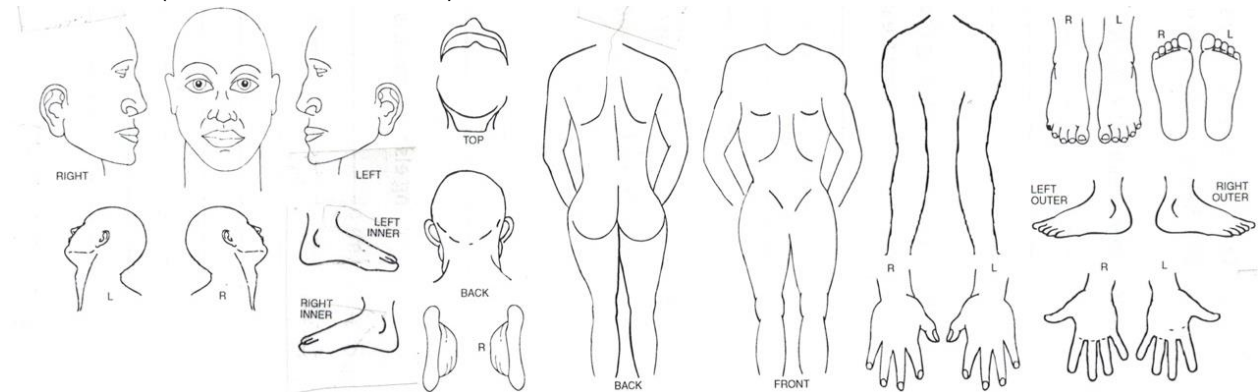
Present medications for your psoriasis, where applied, how frequently, how many days in a row. If you take breaks from your medicines, how long and for which ones/areas? Please include prescription, over the counter, herbal and alternative treatments. Rate whether each product is helping. (1=barely 10=greatly) _____

Other products used on your skin such as, moisturizers, oils, cleansers, sun blocks _____

Lifestyle Changes- meditation, exercise, diet, smoking _____

DOCTOR TO FILL OUT BELOW THE LINE

1/2/3=thin/moderate/thick plaque 3/4/5=minimal/moderate/thick scale 6/7/8=light/dark pink/red
 9=areas of clearing 10/11=hyper/hypopigmentation 12=violaceous 13/14=itch/hurt
 15=arthritis(1=minimal 10=severe) Ex: 15-1 = minimal arthritis, 15-10 =severe arthritis



Assessment: Psoriasis _____ Localized/Generalized Mild/mod/severe _____

%Improved/Worsened _____

Psoriatic Arthritis: None Mild Moderate Severe %Improved/Worsened _____

Possible Side Effects: Skin Thinning/Fragility from steroids, _____

Treatment: _____

RTC _____ Initials _____ Page _____