# Initial Psoriasis Questionnaire

Name_____Birth Date_____Date_____Page____

Age at onset_____Remissions Yes/No_____
What areas of your skin and nails have EVER been involved?_____
_____
How is your psoriasis, today? (1=minimal 10=worst ever)_____
How is psoriasis affecting your life?(1=minor annoyance 10=ruining my life)_____
What is the worst part of your psoriasis?_____
_____
_____
How do you feel today, in general?(1= worst imaginable 10 = glorious)_____
_____
Known triggers for 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)_____
_____
_____
_____
_____
_____
_____
_____
_____
Past treatments which helped but, are not used presently?_____
_____
_____
_____
Past treatments which did NOT work or, made it worse?_____
_____
_____
_____
Side effects from treatments?_____
_____
_____
_____
Other products used on your skin such as, moisturizers, oils, cleansers, sun blocks_____
_____
_____
Genetic relatives with psoriasis_____
Lifestyle- meditation, exercise, diet, smoking, alcohol_____
_____
_____
_____
_____