DMG PATCH TEST REFERRAL QUESTIONNAIRE

Instructions:

- Please mark an "X" in only one box unless otherwise stated in the question.
- Specific instructions are in *italics* within each question.
- Please bring completed questionnaire with you to your first visit.

1. Gender:

☐ male ☐ female

2. Ethnicity:

☐ hispanic ☐ african american ☐ caucasian ☐ asian ☐ pacific islander

☐ other _____

3. Age: _____

4. Please list all medications taken over the past year (*attach separate sheet if required*)
(*include all prescription, over-the-counter products, vitamins, and herbal supplements*)

Current Medications		Past Medications		
Medication	**Start date**	**Medication**	**Start date**	**Stop date**

5. Do you have allergies to any medications?

no ☐ 1

yes ☐ 2 What?_____

6. Date of onset of rash: _____ Site of onset: _____
Description of rash: _____
_____

7. What do you think is/was the cause of your skin rash? (describe onset)
_____
_____

8. What is your occupation? _____ Since when? _____ *(year)*
What is your major activity at work? _____
_____

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9. Do you have hobbies or past time activities?

no ☐

yes ☐ What kind of activities? _____

_____

_____

_____

10. Have you ever had "hay fever" or other symptoms of nasal allergy? *(bouts of sneezing, itchy or runny nose from pollens or animals, etc.)*

☐ no ☐ yes ☐ don't know

11. Have you ever been told you have "eczema" or "atopic dermatitis" ?

☐ no ☐ yes ☐ don't know

If yes, please describe age, location, duration and treatments:

_____

_____

_____

12. Have you ever had asthma?

☐ no

☐ yes. If yes, was it diagnosed by a doctor? no ☐ yes ☐ When?_____ *(year)*

☐ don't know

13. Does anyone in your family have any of the following conditions?

Asthma	☐ yes	☐ no
Hay fever/ seasonal allergies	☐ yes	☐ no
Eczema/atopic dermatitis	☐ yes	☐ no

14. Was the allergy/ were the allergies diagnosed with.... *(mark any that are applicable)*

	Yes	*No*
patch-test *(test are normally taped onto the upper back and removed after 1-2 days)*	☐	☐
skin-prick-tests *(tests drops are normally placed on the forearm and pricked through with lancets or needles. The results are read after 15-30 minutes.)*	☐	☐
blood tests *(e.g., RAST tests)*	☐	☐
other, what?_____	☐	☐
don't know	☐	☐

15. Have you noticed that contact with certain materials, chemicals or anything else makes your rash worse? *(one answer in each colum if applicable)*

☐ no

☐ yes What? _____

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16. How many times do you wash your hands during a usual working day? *(include hand washing during your work and at home/outside work)*

0-5 times per day	☐	6-10 times per day	☐
11-20 times per day	☐	more than 20 times per day	☐

17. Does your rash improve when you are away from your normal work (for example, weekends or longer periods)?

☐ no ☐ yes, sometimes ☐ yes, usually ☐ don't know

18. What type of gloves do you (or did you) use in your work/hobbies? *(mark any that are applicable in each column)*

	At present	Only previously
natural rubber/latex	☐	☐
synthetic rubber (e.g. nitrile, neoprene, etc)	☐	☐
plastic (e.g. vinyl, PVC, polyethene)	☐	☐
cotton gloves underneath rubber or plastic gloves	☐	☐
leather	☐	☐
cloth	☐	☐
other, what?_____		
don't know	☐	☐

19. Review of systems *(please mark all that apply)*

CONSTITUTIONAL SYMPTOMS

☐ none
☐ unintentional weight loss
☐ fever
☐ special diet
☐ other: _____

RESPIRATORY

☐ normal
☐ asthma
☐ other: _____

CARDIOVASCULAR

☐ normal
☐ angina
☐ hypertension
☐ heart attack
☐ artificial heart valve
☐ other: _____

NEUROLOGICAL

☐ normal
☐ strokes
☐ seizures
☐ other: _____

SKIN

☐ rash
☐ keloids
☐ poor healing
☐ hives
☐ other: _____

PSYCHIATRIC

☐ normal
☐ depression
☐ anxiety attacks
☐ other: _____

HEMATOLOGIC/ LYMPHATIC

☐ normal
☐ anemia (low blood count)
☐ other: _____

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GASTROINTESTINAL

☐ normal

☐ stomach ulcer

☐ other: _____

ENDOCRINE

☐ normal

☐ diabetes

☐ thyroid problems

EYES / EARS / NOSE / THROAT

☐ normal

☐ glaucoma

☐ hearing aid

☐ cosmetic surgery

MUSCULOSKELETAL

☐ normal

☐ arthritis (joint pain)

☐ **artificial joint**

If yes-- please explain where, what kind of metal, year of placement

_____

_____

_____

_____

_____

Is your physical activity limited?

☐ yes ☐ no

_____

_____

_____

_____

(please describe)

INFECTIONS

☐ none

☐ hepatitis

☐ HIV/AIDS

☐ tuberculosis (TB)

☐ other: _____

20. Please list all **topical** medications used over the past year
(include all prescription, over-the-counter products, vitamins, and herbal supplements)

Current Medications	Past Medications

(attach separate sheet if required)

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21. Please list all your personal care and cosmetic products
(be as specific as possible, please feel welcome to attach additional sheets or photos if necessary)

Soap	
Body lotion	
Hand lotion	
Facial makeup	
Base	
Blush	
Eye products	
Eyelash curler	
Lipstick	
Deodorant	
Cologne, perfume	
Shaving cream	
Hair dye, bleach, etc.	
Laundry detergent	
Nail cosmetics, wraps	
Toothpaste	
Contact lenses	
Shampoo	
Other	