Psoriasis Questionnaire

How long have you had psoriasis? _____ or age it began? _____

What flares your psoriasis? _____

Is there a family history of psoriasis? □ Yes □ No or psoriatic arthritis? □ Yes □ No

Prior Treatments (please write out specific names):

□ Topical medications (circle): tazarotene, calcipotriene, triamcinolone, betamethasone, clobetasol, halobetasol, fluocinonide, fluocinolone, desonide, alclometasone, coal tar, other - _____

□ Light therapy, PUVA, or laser/XTRAC therapy - _____

□ Pills (circle): Otezla, acitretin, Soriatane, methotrexate, cyclosporine, other - _____

□ Biologic injections (circle): Enbrel, Humira, Cimzia, Remicade, Stelara, Taltz, Cosentyx, Skyrizi, Tremfya, Siliz, Ilumya, other - _____

□ Natural Supplements or OTC treatments - _____

_____

Arthritis / Joint Involvement: (3/5)

Have you ever had a swollen joint (or joints)? □ Yes □ No

Has a doctor ever told you that you have arthritis? □ Yes □ No Which type? _____

Do your fingernails or toenails have holes or pits? □ Yes □ No

Have you had pain in your heel? □ Yes □ No

Have you had a finger or toe that was completely swollen and painful for no apparent reason? □ Yes □ No

Current Health:

Height _____ Weight _____

Do you smoke? □ Yes □ No Have you ever smoked? □ Yes □ No Are you around smokers? □ Yes □ No

Stress Level: □ Low □ Moderate □ High

Do you like spicy food? □ Yes □ No

Number of drinks per week: _____ Sodas _____ Juice _____Sweetened drinks / Gatorade

Number of alcoholic beverages per week: _____

Current diet: □ Typical American Diet □ Primarily Fast Food □ Low Fat Diet
□ Low Carb / Keto Diet □ Vegetarian / Vegan □ Mediterranean Diet
□ Other: _____

Typical Meals:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Past Health History:

Have you had any root canals? □ Yes □ No

Has your gallbladder been removed? □ Yes □ No

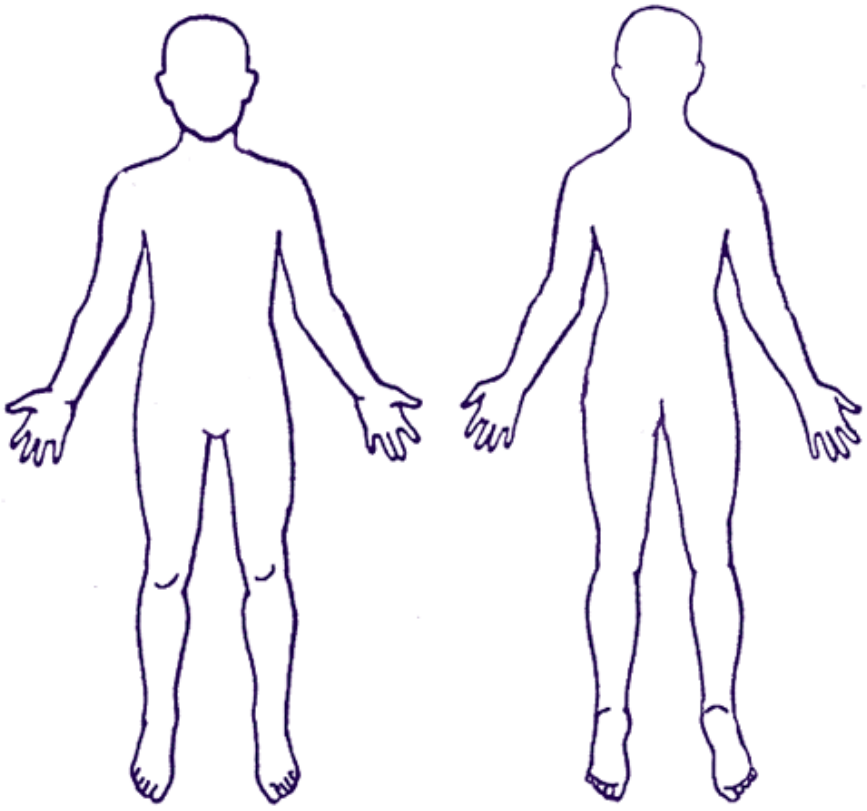
Do you have the following? □ Diabetes / Prediabetes □ High cholesterol
□ High blood pressure □ Heart disease
□ Crohn's disease or colitis □ Depression or history of depression
□ History of kidney issues □ History of cancer - type: _____
□ Family history of cancer – type: _____
□ Needle phobia

Current Medications: _____
_____

What psoriasis treatments are you interested in?

□ Prescription creams only □ Pills / More aggressive treatment □ Biologic injections
□ Laser / light treatment □ Natural options

Please mark all the areas where you currently have psoriasis:



BSA :
WEIGHT:

Name _____ Date _____