

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: _____

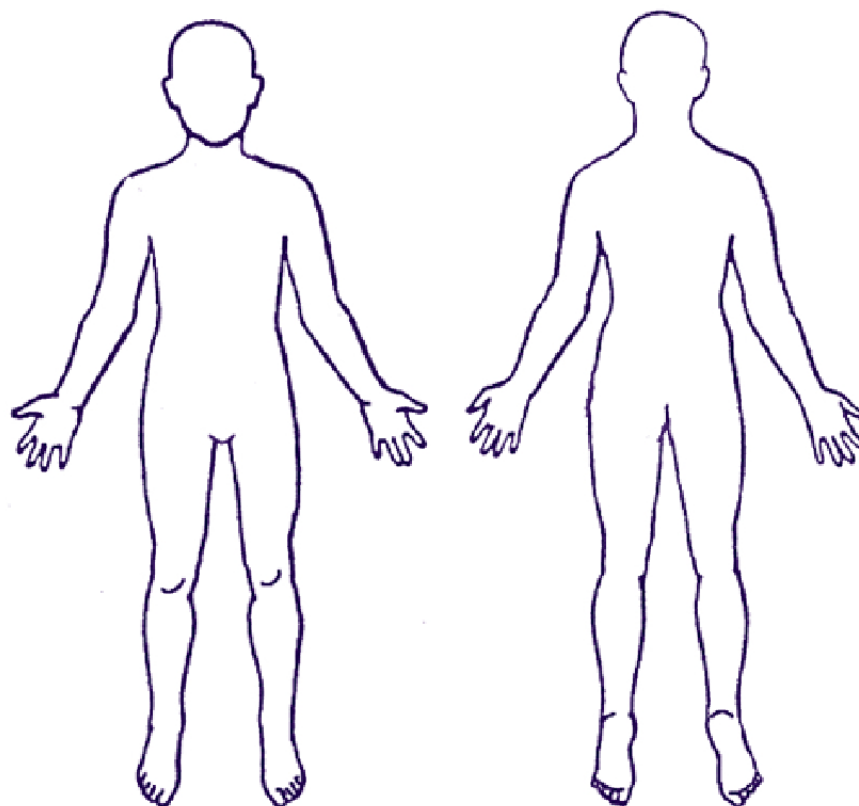
☐ Needle phobia

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 _____