EXPOSURE QUESTIONNAIRE: (PLEASE RETURN THIS QUESTIONNAIRE BACK TO THE OFFICE ASAP)

Name: _____ Date of Birth: _____
Address: _____
Email address: _____ Today's Date: _____
Phone number: (cell) _____ (home) _____ (office) _____
Claim Number: _____ Employer: _____

PRESENT ILLNESS

Date of onset: When did the problem begin? _____
Initial Symptoms: _____-
_____
_____
___

Check off all symptoms you WERE experiencing: ☐ Blisters ☐ Itching ☐ Pain
☐ Burning ☐ Redness ☐ Cracking ☐ Bleeding ☐ Oozing/weeping

Current symptoms: Are you having a problem with your skin now? Where on your skin is your current problem located?
_____
_____
_____

Treatment:
_____

Have you recently taken oral steroids (prednisone)? ☐ Yes or ☐ No. If yes, when? _____
Have you recently had a steroid injection (Kenalog)? ☐ Yes or ☐ No. If yes, when? _____

What happens to your rash while you are away from work?

- Weekends: ☐ Improves ☐ Worsens ☐ Stays the Same
- Vacations: ☐ Improves ☐ Worsens ☐ Stays the Same
- Layoffs (*if applicable)*: ☐ Improves ☐ Worsens ☐ Stays the Same ☐ N/A
- Disability (*if applicable)*: ☐ Improves ☐ Worsens ☐ Stays the Same ☐ N/A

Suspect exposure: What do you think is causing the problem?
_____
_____
_____

Physicians or other providers seen for problem:

1. _____
2. _____
3. _____

WORK HISTORY

Employer at the onset of rash: _____
Duration of Employment (dates): _____ to _____
Job Title: _____
Job Description at the onset:

_____
_____
_____

Is your current job the same as above? ☐ Yes or ☐ No

If no, what is your current job title? _____
Current job description:

_____
_____
_____

Are you currently working? ☐ Full-time ☐ Part-time ☐ Not currently working

Previous jobs with same employer: Have you had other jobs with the same employer? ☐ Yes or ☐ No
When? _____ Job Description?
_____

Second job at the same time the dermatitis developed: Did you have a second job when the rash came on? ☐ Yes or ☐ No
Employer: _____ Job Description?
_____

Previous Employment:

1. **Employer:_____**
    - **Dates employed:** _____ to _____
    - **Job title: _____**
    - **Did you have skin problems while working here?** ☐ Yes or ☐ No
2. **Employer:_____**
    - **Dates employed:** _____ to _____
    - **Job title: _____**
    - **Did you have skin problems while working here?** ☐ Yes or ☐ No
3. **Employer:_____**
    - **Dates employed:** _____ to _____
    - **Job title: _____**
    - **Did you have skin problems while working here?** ☐ Yes or ☐ No

Work exposures and contactants: this includes gloves (what type – latex, vinyl, blue, yellow, nitrile, cotton, garden gloves etc and what brand), and any chemicals that touch your skin while you are working; including cleaning agents such as soaps. Do you have MSDS (Material Safety Data sheets) for these products?

_____ _____

_____ _____
_____ _____
_____ _____
_____ _____

Hand washing: # times/day: _____

- Brand of the soap/cleanser/hand sanitizer you use at work? _____

Protective creams/cleanser/clothing: _____
Cleanliness of the work environment: _____
Trauma: ☐ Yes ☐ No
Humidity, temperature extremes or sweating: ☐ Yes ☐ No if yes, explain: _____
Other workers affected: Do other employees have a similar problem? ☐ Yes ☐ No

If yes:

- Number affected: _____
- Number of workers on the job:_____

Exposures:		Yes	No	Don't Know
1	Do you have piercings?	☐	☐	☐
2	Have you ever used topical anesthetics?	☐	☐	☐
3	Do you or your parent dye your/his/her hair?	☐	☐	☐
4	Have you ever had a temporary black henna tattoo?	☐	☐	☐
5		☐	☐	☐
6	Have you ever used antibiotic ointments/creams?	☐	☐	☐
7	Have you ever used corticosteroid creams/ointments?	☐	☐	☐
8	Have you even taken antihistamines or cold and flu syrup?	☐	☐	☐
9	Have you ever used baby shampoo?	☐	☐	☐
10	Have you ever used liquid hand soaps?	☐	☐	☐
11	Have you ever used baby wipes?	☐	☐	☐
12	Have you ever used neoprene or rubber grips on sports gear?	☐	☐	☐
13	Have you ever used nail polish?	☐	☐	☐
14	Have you ever worn acrylic nails?	☐	☐	☐
15	Have you ever used eye drops (over the counter or prescription)?	☐	☐	☐

Have you ever developed a reaction (rash, itching, etc.) to any of the following?	Yes	No	Don't Know
a Jewelry (watches, earrings, rings, etc.)	☐	☐	☐
b Toothpaste or mouthwash	☐	☐	☐
c Hair dye	☐	☐	☐
d Henna tattoos	☐	☐	☐
e Permanent tattoos	☐	☐	☐
f Inks, paints, markers, dark clothing	☐	☐	☐
g Perfumes or colognes	☐	☐	☐
h Vaccines or medications	☐	☐	☐
j Antibiotic creams/ointments	☐	☐	☐
l Shampoos, body wash or bath gels	☐	☐	☐
m Liquid hand soaps	☐	☐	☐
n Shoes	☐	☐	☐
o Moisturizers, creams or lotions	☐	☐	☐
p Bandage or adhesive tapes	☐	☐	☐
q Baby wipes	☐	☐	☐
r Cosmetics/Make-up	☐	☐	☐

CONTACTANTS

Toiletries and cleansers: What are your personal skin care products (name and brand)? *Write <u>none</u> in the space provided if you do not use that type of product.*

- Perfumes/cologne: _____
- List out all cosmetics you were using when the rash first began and cosmetics you are currently using

  _____

  _____
- Name of Shampoo or other hair products you have used since the onset of the rash:

  _____
- Name of moisturizers:

  _____
- Deodorant:

  _____
- Name of Soaps (bar and liquid):

  _____

- Household cleaners and laundry products:
  _____
- How often do you wash your hands at home? _____ Do you wash your hands over 20 times? ☐ Yes ☐ No
- Are you right or left handed? ☐ Right ☐ Left
- Do you wear gloves at home? ☐ Yes ☐ No. If yes, what type
  _____
- Do you use any of the following:
  - Bag Balm: ☐ Yes ☐ No
  - Vitamin E: ☐ Yes ☐ No
  - Neosporin: ☐ Yes ☐ No
- Do you use any other topical products:
  _____

Other contactants: What other things do you come into contact with that might be causing a problem with your skin?

1. Animals: **(a)** Do you have a pet? **(b)** Do you give your pet any medications or bathe them? ☐ *Mark this box if no pets*
   _____
   _____
   ____
2. Foods: Do certain foods cause your skin to break out with a rash? ☐ Yes ☐ No
   _____
   __
3. Plants: Are you allergic to any plants? ☐ Yes ☐ No If yes:
   _____
4. Clothing: Does clothing cause your skin to break out? ☐ Yes ☐ No
   _____
   __
5. Jewelry: **(a)** Do you wear jewelry (rings, earrings, watch) **(b)** Are you allergic to jewelry, including costume jewelry? **(c)** If yes, what happens? ☐ *Mark this box if you do not wear jewelry*
   _____
   __
6. Number of body piercings: _____ Location of piercings:
   _____
7. Please list your partners (husband, wife, and roommate) products different than yours: This would include hair gels, shaving products, fragrances, body lotions, etc? ☐ *Mark this box if you live alone*
   _____
   _____
   ____
8. Does anyone in your household smoke? ☐ Yes ☐ No
9. Other substances you come into contact with that we have not asked about:
   _____
   __

LATEX HISTORY

Do you think you are allergic to latex rubber? ☐ Yes ☐ No
If yes, please explain:

_____
_____
_____

- Do you have problems with latex rubber exposure in the following settings?
  - **Dental exams**: ☐ Yes ☐ No
  - **Medical exams**: ☐ Yes ☐ No
  - **Condoms**: ☐ Yes ☐ No

- When you eat the foods listed below (foods related to latex rubber allergy), do you have any problems with your skin breaking out, including swelling of the lips, redness, shortness of breath, or a rash?
  - **Avocado**: ☐ Yes ☐ No ☐ Do not eat
  - **Banana**: ☐ Yes ☐ No ☐ Do not eat
  - **Chestnut**: ☐ Yes ☐ No ☐ Do not eat
  - **Peaches**: ☐ Yes ☐ No ☐ Do not eat
  - **Kiwi**: ☐ Yes ☐ No ☐ Do not eat

SKIN HISTORY

- Have you been patch tested in the past? ☐ Yes ☐ No
  - If yes, when? _____ What were you allergic to? _____
- Hay fever: Do you have runny eyes or runny nose during different seasons? ☐ Yes ☐ No
  - Problems with: Animal Dander? ☐ Yes ☐ No Pollen? ☐ Yes ☐ No
- Do you have personal history of any of the following:
  - Asthma: ☐ Yes ☐ No
  - Flexural eczema: ☐ Yes ☐ No
  - Seborrheic dermatitis: ☐ Yes ☐ No
  - Psoriasis: ☐ Yes ☐ No
  - Herpes simplex: ☐ Yes ☐ No
  - Athlete's foot/fungal infections: ☐ Yes ☐ No
  - Sun sensitivity: ☐ Yes ☐ No
    - Do you get hives when you are in the sun? ☐ Yes ☐ No
    - Do you get a rash when you go out in the sun? ☐ Yes ☐ No
  - Skin cancer: ☐ Yes ☐ No
  - Hives/urticaria: ☐ Yes ☐ No
  - Allergy to poison oak/ivy: ☐ Yes ☐ No

- Do you have any other skin problems (past/present) that we have not yet asked about? If you do, please explain the problem and how you treat it?

  _____
  _____
  _____

PAST MEDICAL HISTORY

- Illness: Are you treated for any medical problems like diabetes, hypertension, etc?
  _____
  _____
  _____
- Operations/Hospitalizations: *Please list all of your operations and dates:*
  _____
  _____
  _____
- Do you have any implanted metals (hip, knee, jaw, etc.)? ☐ Yes or ☐ No? If yes, where are they located and what are they made of?
  _____
- Injuries: Have you had a major injury?
  _____
  ___
- Allergies to medications: ☐ Yes or ☐ No? If yes, which ones and what happens?
  - _____ _____
  - _____ _____
- **Any other relevant history?**
  _____

MEDICATIONS/VITAMINS/SUPPLEMENTS

Please list all your medications including supplements like vitamins, calcium, herbal remedies, nutritional supplements, over the counter medications like aspirin, Tylenol and prescription medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY

- Please check: ☐ Single ☐ Partner ☐ Married
- Children: ☐ Yes ☐ No?
  - If yes, how many and what ages? _____
- Military service: ☐ Yes ☐ No?
- Highest level of education: _____
- Tobacco use: ☐ Yes ☐ No?
  - If yes, how much per day? _____
- Illicit drug use: ☐ Yes or ☐ No?
- Weight loss or weight gain: ☐ Loss or ☐ Gain or ☐ Neither. How much? _____
- Who lives with you: _____

HOBBIES/ACTIVITIES

What are your hobbies? Please list all the activities that you do in your spare time.
Do you use glues, paints, oils, greases, woods, plants, gloves?

_____
_____
_____
_____
___

FAMILY HISTORY: do you have a family history of any skin problems?

- Eczema: ☐ Yes ☐ No
- Hay fever: ☐ Yes ☐ No
- Asthma: ☐ Yes ☐ No
- Psoriasis: ☐ Yes ☐ No
- Seborrheic dermatitis: ☐ Yes ☐ No
- Autoimmune disease (lupus, rheumatoid arthritis, scleroderma, diabetes, etc.): ☐ Yes ☐ No
    - If yes, please explain:
      _____
- Any other relevant family history:
  _____
  ___
  _____
  ___

Thank you for taking the time to complete this form. This information is invaluable in helping us determine the cause of your dermatitis. Please do not hesitate to give us a call with any questions about your upcoming visit.

Patricia Norris, M.D.
Board Certified Dermatology