# Eczema questionnaire

For adults and children with eczema (atopic dermatitis).

Please type your answers into this form (or print and fill it in), save it, and email it to **referrals@vidamedical.com.au** at least **7 days before your appointment**. Skip anything that doesn't apply. If you are completing this for a child, answer for the child.

## About you

**Full name**

**Date of birth**

**Today's date**

**Phone and email**

**Completed by (if not the patient)**

**Usual GP and clinic**

## Your eczema

**Age eczema started**

**Where is it now?**

- ☐ Face
- ☐ Neck
- ☐ Hands
- ☐ Inside elbows
- ☐ Behind knees
- ☐ Trunk
- ☐ Feet
- ☐ Nappy area
- ☐ All over

## How it is right now

**How itchy has the skin been over the past week?**

Not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely

**How much has eczema disturbed sleep over the past week?**

Not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely

**Overall, how much does eczema affect daily life right now?**

Not at all ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely

**Number of flares in the past 3 months**

**In the past month, has the skin been:**

- ☐ Bleeding
- ☐ Weeping or oozing
- ☐ Cracked
- ☐ Crusted or yellow
- ☐ Thickened
- ☐ Clear most of the time

## What makes it worse?

- ☐ Heat or sweating
- ☐ Winter or dry air
- ☐ Soaps or bubble bath
- ☐ Wool or rough fabrics
- ☐ Stress
- ☐ Dust
- ☐ Pets
- ☐ Pollen season
- ☐ Particular foods
- ☐ Infections
- ☐ Not sure

**If you suspect foods, which ones and what happens?**

## Treatments

| Treatment | Name | How often? | Did it help? |
|---|---|---|---|
| **Moisturiser** | | | |
| **Steroid cream** | | | |
| **Other prescription cream** | | | |
| **Wet wraps or bleach baths** | | | |
| **Antibiotics for infected skin** | | | |
| **Tablets or injections** | | | |

Have you ever had infected eczema (weeping, crusting, cold sores spreading)? ☐ Yes ☐ No ☐ Unsure

## Medicines

**All medicines you take, including sprays, creams, vitamins and supplements**

**Do you take any of these?**

- ☐ Antihistamines (e.g. Telfast, Zyrtec, Claratyne)
- ☐ Blood pressure or heart medicines
- ☐ Regular ibuprofen or aspirin
- ☐ Adrenaline autoinjector (EpiPen / Anapen)

**Autoinjector expiry date (if you have one)**

## Family history

**Does a parent, brother or sister have:**

- ☐ Food allergy
- ☐ Eczema
- ☐ Asthma
- ☐ Hay fever
- ☐ Hives
- ☐ Not sure

## Your goals

**What would you most like to get out of this appointment?**

**Previous allergy tests (type, date, result). Please bring copies if available.**

## Before you arrive

**Medicines:** antihistamines and some other medicines can affect allergy testing. We'll email you instructions on which to pause and when. **Keep taking your asthma medicines.**

**Bring:** previous test results, photos of any reactions, and your adrenaline autoinjector if you have one.

Your information is confidential and stored in your medical record in line with our privacy policy.