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PATCH TESTING

1. When did the rash appear? ______________________________
2. What part of the body did it involve? ______________________________
3. What have you used as treatment for the rash? ______________________________
4. Do you have a history of:

	YES	NO
Skin itching	________	________
Drug reaction	________	________
Food reaction	________	________
Animal reaction	________	________
Plant reaction	________	________
Dry skin	________	________
Hay fever	________	________
Sinusitis	________	________
Asthma	________	________
Hives	________	________
Reaction to jewelry	________	________
Reaction to latex or rubber	________	________
Reaction to elastic	________	________

5. Do you think that your rash is made worse by contact with any of the following (Please circle):

Nail polish	Deodorant
Detergent	Soap
Cosmetic	Animal
Hair product	Work chemical
Other ______________________	

6. Is the rash affected by food or medication? ______________________________
7. What is your occupation? ______________________________
8. Any history of medical illnesses ? (Please list) ______________________________

   ____
9. Are you currently taking any medications? (Please list) ______________________________

   ____
10. Any history of surgery? (Please list) ______________________________

    ____
11. Do you have a family history of allergies? ☐ Yes ☐ No

    If yes, please explain: ______________________________
12. Do you smoke? ☐ Yes ☐ No

Please tell the doctor or nurse in advance if you are pregnant. Please Call our office if you have questions or concerns.

Thank you very much for taking the time to answer these questions.

PATIENT NAME ______________________ **MEDICAL RECORD #**______________