ATOPIC DERMATITIS (ECZEMA) QUESTIONNAIRE

PATIENT NAME ______________________________________ DATE__________________________

1. Have you had itchy skin in the past year, with frequent scratching of the skin? ☐**YES** ☐**NO**
2. How old were you when this skin condition began? ☐**Under 1y** ☐ 1 **to 2 y** ☐**Over 2 yrs old**
3. Does the itchy skin condition affect any of the following locations of the body now?

   In the scalp? ☐**YES** ☐**NO**

   Around the eyes? ☐**YES** ☐**NO**

   On the cheeks or around the mouth? ☐**YES** ☐**NO**

   Around the elbows or knees? ☐**YES** ☐**NO**

   Around the wrist or ankle? ☐**YES** ☐**NO**

4. Does your itchy skin disturb your sleep at least one night per week? ☐**YES** ☐**NO**
5. Do you feel your skin condition is uncontrolled? ☐**YES** ☐**NO**
6. What over-the-counter moisturizer (lotion) do you use? _________________________________
7. How often do you use moisturizer? ☐**<once/wk** ☐ **2-3 times/wk** ☐**once/day** ☐**>once/day**
8. What prescription cream(s) do you use? ____
9. How often do you use prescription cream? ☐**<once/wk** ☐ **2-3 times/wk** ☐**once/day** ☐**>once/d**
10. What anti-itch medication do you use? ☐**Benadryl** ☐ **Hydroxyzine** ☐**Cyprohepatdine** ☐**Other**
11. Have you been treated with antibiotics in the past year for a skin infection? ☐**YES** ☐**NO**