Dermatology of the Berkshires, P.C.
Victoria R. Cavalli, M.D.
40 Main Street · North Adams, MA 01247 · (413)663-6769

PSORIASIS PATIENT INFORMATION SHEET

Name:____ DOB: ________________________ Date: ___________

How long have you had psoriasis? ____

Please list involved areas: ____

Did you have an infection before the psoriasis started (such as strep throat or a respiratory virus)? ___________

____

What makes it better? ____

What makes it worse? ____

Is it better in the winter or summer? ____

Is it itchy or painful? ____

Do you have any nail changes, fevers or arthritis? ____

Please list any prescription or over-the-counter treatments (i.e. topical steroids, tar, Dovonex, Tazorac, Elidel, Protopic, Anthralin, ultraviolet radiation, PUVA): ____

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Have you had systemic therapy (such as Prednisone, Methotrexate, Soriatane, Cyclosporine, Enbrel/Humira)?

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If yes, when did you have it? ____

Did it help? ____