

Dermatology of the Berkshires, P.C.

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RASH PATIENT INFORMATION SHEET

Name: _____ DOB: _____ Date: _____

When and where did the rash start? _____

Please list involved areas (scalp, face, neck, chest, abdomen, back, arms, hands, legs, feet, buttocks, genital area): _____

Is the rash itchy or painful? _____

Is the rash disrupting your sleep? _____

Have you had this rash (or a similar one) before? _____

If yes, is the rash seasonal? _____

Please list any triggers or exposures: _____

What makes the rash better? _____

What makes the rash worse? _____

Does anyone else in your household have a similar rash? _____

Do you have any pets at home? _____

Please list medications or treatments you or your doctor tried (either prescription or over-the-counter pills or creams): _____