

Pre-visit psoriasis screening questionnaire

Patient information

Name: _____

Date of Birth: _____

Today's Date: _____

Contact Information: _____

Signs and symptoms

1. Do you currently have any of the following symptoms? (Check all that apply)

- ☐ Red patches of skin covered with thick, silvery scales
- ☐ Dry, cracked skin that may bleed
- ☐ Itching, burning, or soreness in affected areas
- ☐ Thickened, pitted, or ridged nails
- ☐ Joint pain, stiffness, or swelling (especially in fingers, toes, or back)

If yes to "joint pain, stiffness, or swelling," which joints are affected? (Check all that apply)

- ☐ Fingers
- ☐ Toes
- ☐ Wrists
- ☐ Knees
- ☐ Ankles
- ☐ Lower back
- ☐ Other: _____

If yes to "joint pain, stiffness, or swelling," is the pain worse in the morning or after periods of inactivity?

- ☐ No
- ☐ Yes

Where on your body have you experienced symptoms? (Check all that apply)

- | | |
|--------------------------------|---------------------------------------|
| ☐ Scalp | ☐ Feet |
| ☐ Face | ☐ Genitals |
| ☐ Neck | ☐ Breasts |
| ☐ Chest | ☐ Hands |
| ☐ Back | ☐ Elbows |
| ☐ Legs | ☐ Nails |
| ☐ Knees | ☐ Other: _____ |

When did you first notice these symptoms?

Please describe the approximate timeline: _____

2. Does your rash/symptoms flare with exposure to any of the following triggers? (Check all that apply)

- ☐ Stress
- ☐ Infections (eg, sore throat, colds)
- ☐ Skin injuries (cuts, sunburn, etc.)
- ☐ Certain medications (eg, beta-blockers, over-the-counter pain relievers, lithium)
- ☐ Cold weather
- ☐ Smoking
- ☐ Alcohol use
- ☐ Other: _____

Medical and family history

3. Have you been previously diagnosed with psoriasis by a healthcare provider?

- ☐ No
- ☐ Yes

4. Have you ever been diagnosed with psoriatic arthritis or any other autoimmune condition (eg, rheumatoid arthritis, lupus)?

- ☐ No
- ☐ Yes

If yes, please describe: _____

5. Do you have a history of any of the following?

- ☐ Hypertension (high blood pressure)
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Overweight/Obesity
- ☐ Cardiovascular disease
- ☐ Depression or anxiety
- ☐ Other: _____

6. Do you have a family history of psoriasis?

- ☐ No
- ☐ Not sure

If not sure, please provide additional detail as needed: _____

- ☐ Yes

If yes, please list the relationship (eg, parent, sibling): _____

Lifestyle factors and comorbidities

7. Do you smoke or use tobacco products?

- ☐ Never smoked
- ☐ Former smoker. Please specify number of packs per day and duration: _____
- ☐ Current smoker. Please specify number of packs per day and duration: _____
- ☐ Occasional smoker. Please specify number of packs per day and duration: _____

8. How often do you drink a beverage with alcohol?

- ☐ Never
- ☐ Monthly or less
- ☐ 2–4 times a month
- ☐ 2–3 times a week
- ☐ 4 or more times a week

9. Do you believe your skin condition affects your quality of life (eg, emotional health, work, social interactions)?

- ☐ No
- ☐ Yes

If yes, how: _____

Current medications and treatment

10. Are you currently taking any medications, including over-the-counter or herbal supplements?

- ☐ No
- ☐ Yes

If yes, please list: _____

11. Have you ever used treatments for psoriasis (eg, topical creams, oral medications or injections, light therapy)?

- ☐ No
- ☐ Yes

If yes, which ones, how long did you use them for, and how effective were they?

12. Have you ever had treatments for psoriasis prescribed by a doctor that you did not use for any reason (eg, because insurance wouldn't cover etc.)?

- ☐ No
- ☐ Yes

If yes, which ones and what were the reasons for not using them?

13. What are your key goals for managing your psoriasis?

Additional comments

Is there anything else you would like your healthcare provider to know about your condition or symptoms?

