Initial (OCTRI 10346)

Please complete this survey as best you can. Your answers are greatly appreciated and will help the study of psoriasis.

Office Use

Subject ID _____

Visit Date _____

Form Version _____

Weight (kg) _____

% BSA _____

Systolic Blood Pressure (mmHg) _____

Diastolic Blood Pressure (mmHg) _____

PATIENT INFORMATION

Height (cm) _____

Date of Birth _____

Gender

☐ M ☐ F

Ethnicity

☐ White / Caucasian ☐ Native American / American Indian ☐ Hispanic or Latino ☐ Other (please specify)
☐ Black / African-American ☐ Asian / Asian-American ☐ Native Hawaiian / Pacific Islander

If Other Ethnicity, please specify

_____

Are you currently employed

☐ Yes ☐ No

If Yes, what is your personal yearly salary?

☐ 0-$24,999 ☐ $25,000-$49,999 ☐ $50,000-$74,999 ☐ $75,000-$99,999 ☐ >$100,000

What is your occupation? (past and present) _____

Please list any materials/chemicals you are in contact with:

Are you on disability?

☐ Yes ☐ No

If Yes, please describe the reason for disability. Reason 1

_____

Reason 2

_____

Alcohol, Tobacco, Other

Do you drink alcohol?

☐ Yes ☐ No

If Yes, what type of alcohol do you consume?

_____

How often did you have a drink containing alcohol? (Frequency)

☐ Never ☐ Less than Monthly ☐ 2-4 times per month ☐ 2-3 times per week ☐ 4 or more times per week

How many drinks containing alcohol did you have on a typical day when you were drinking? (Frequency)

☐ 0 - Don't drink ☐ 1 to 2 ☐ 3 to 4 ☐ 5 to 6 ☐ 7 to 9 ☐ 10 or more

How often did you have six or more drinks on one occasion? (Frequency)

☐ Never ☐ Less than Monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Have you felt that you might have an alcohol problem, been diagnosed with an alcohol problem, or been in detox, hospitalized, or otherwise treated for an alcohol problem?

☐ Yes ☐ No

Are you currently smoking cigarettes?

☐ Yes ☐ No

If yes, how many cigarettes consumed per day? (Cigarettes/day)

_____

How many years have you smoked cigarettes? (Years)

_____

If No, do you have a Past history of cigarette use?

☐ Yes ☐ No

If Yes, how many cigarettes consumed per day? (Cigarettes/day)

_____

How many years have you smoked cigarettes? (Years)

_____

Do you use recreational, nonprescribed drugs?

☐ Yes ☐ No

Have you felt that you might have a drug problem, been diagnosed with a drug problem, or been in detox, hospitalized or otherwise treated for a drug problem? (Frequency)

☐ Never ☐ In the Past ☐ In the Last Year

Psoriasis

Age at time psoriasis began _____

Age at time psoriasis was diagnosed by a doctor _____

RASHES AND LESIONS Please select "Current" for areas where you have Current rashes or lesions from psoriasis. Please select "Past" for areas where you've had lesions of psoriasis in the Past.

Scalp

☐ Current ☐ Past

Ears

☐ Current ☐ Past

Elbow/knees

☐ Current ☐ Past

Arms/legs

☐ Current ☐ Past

Trunk

☐ Current ☐ Past

Buttocks

☐ Current ☐ Past

Face

☐ Current ☐ Past

Perianal/genital

☐ Current ☐ Past

Under arms/in folds

☐ Current ☐ Past

Palms/soles

☐ Current ☐ Past

Nails

☐ Current ☐ Past

Do you or have you had pus bumps on your palms or soles?

☐ Yes ☐ No

Have you had complete body redness with scale?

☐ Yes ☐ No

Have you had a sudden eruption of numerous teardrop-shaped lesions?

☐ Yes ☐ No

Do you know of any blood relatives who have had psoriasis?

☐ No ☐ Yes ☐ Not Sure

If Yes, which family members have had psoriasis?

Mother

☐ Yes ☐ No

Father

☐ Yes ☐ No

Brother

☐ Yes ☐ No

Sister

☐ Yes ☐ No

Son

☐ Yes ☐ No

Daughter

☐ Yes ☐ No

Maternal Grandmother

☐ Yes ☐ No

Maternal Grandfather

☐ Yes ☐ No

Paternal Grandmother

☐ Yes ☐ No

Paternal Grandfather

☐ Yes ☐ No

Maternal Cousin

☐ Yes ☐ No

Paternal Cousin

☐ Yes ☐ No

Maternal Aunt

☐ Yes ☐ No

Maternal Uncle

☐ Yes ☐ No

Paternal Aunt

☐ Yes ☐ No

Paternal Uncle

☐ Yes ☐ No

Other

☐ Yes ☐ No

Have you noticed anything that makes your psoriasis worse?

☐ Yes
☐ No

If Yes, what makes your psoriasis worse? (Select all that apply)

Stress

☐ Yes ☐ No

Summer season

☐ Yes ☐ No

Skin trauma

☐ Yes ☐ No

Strep throat

☐ Yes ☐ No

Medications

☐ Yes ☐ No

Winter season

☐ Yes ☐ No

Hormonal

☐ Yes ☐ No

Other

☐ Yes ☐ No

If Other, please describe Other

_____

Have you noticed anything that makes your psoriasis better?

☐ Yes ☐ No

If Yes, what improves your psoriasis? (Select all that apply)

Spontaneous improvement

☐ Yes ☐ No

Summer season

☐ Yes ☐ No

Pregnancy

☐ Yes ☐ No

Treatment

☐ Yes ☐ No

If Treatment, please describe Treatment

_____

Other

☐ Yes ☐ No

If Other, please describe Other

_____

Psoriatic Arthritis

Do you have psoriatic arthritis?

☐ No ☐ Yes ☐ Not Sure

If Yes, what type of doctor told you?

☐ Rheumatologist ☐ Dermatologist ☐ Other

If Other, please describe Other

_____

What age were you diagnosed? (Years)

_____

Do you have stiffness in the morning?

☐ Yes ☐ No

If Yes, how long does the stiffness last? (Minutes)

_____

Do you currently have joint stiffness after being still for periods of time?

☐ Yes ☐ No

Do you have a history of joint pain or swelling?

☐ Yes ☐ No

Please select "Current" for areas where you have Current joint pain or swelling or select "Past" for areas where you've had joint pain or swelling in the Past. Select all that apply.

Hands

☐ Current ☐ Past

Elbows

☐ Current ☐ Past

Shoulders

☐ Current ☐ Past

Spine/Back

☐ Current ☐ Past

Feet

☐ Current ☐ Past

Ankles

☐ Current ☐ Past

Knees

☐ Current ☐ Past

Hips

☐ Current ☐ Past

Have you had X-rays taken of your joints?

☐ Yes ☐ No

If Yes, when were the X-rays first taken? (Year)

_____

Does psoriasis or psoriatic arthritis affect your ability to work?

☐ Yes ☐ No

If yes, to what extent is your ability to work decreased? (fill one)

☐ Mildly ☐ Moderately ☐ Severely ☐ Unable to work

Life Effects

Please select the ONE best answer for your abilities at this time. Over the LAST WEEK, were you able to:

Dress yourself, including tying shoelaces and doing buttons?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Get in and out of bed?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Lift a full cup or glass to your mouth?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Walk outdoors on flat ground?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Wash and dry your entire body?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Bend down to pick up clothing from the floor?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Turn regular faucets on and off?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Get in and out of a car, bus, train or airplane?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Walk 2 miles or 3 kilometers, if you wish?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Participate in recreation and sports as you would like, if you wish?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Get a good night's sleep?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Deal with feelings of anxiety or being nervous?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

Deal with feelings of depression or feeling blue?

☐ Without ANY Difficulty ☐ With SOME Difficulty ☐ With MUCH Difficulty ☐ UNABLE to DO

How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate how severe your pain has been No pain = 0, Pain as bad as it could possibly be = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing Very well = 0, Very Poorly = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Psoriasis Treatments

"The next section will ask you to provide information about your treatment history for Psoriasis. Please answer to the best of your ability. Consider medications you are currently taking or have taken in the past. Select ""Current"" to indicate you are Currently taking a medication. Select ""Past"" to indicate a medication you have taken in the Past. If you have never taken a medication leave it blank and skip to the next medication. Please list how long you have been taking or how long you took a medication in the past. Mark whether they have helped and what side effects or reactions you experienced. Please include over the counter and naturopathic products.

TOPICAL

Tar/anthralin

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Vitamin D3 (Dovonex)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Topical steroids

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Topical retinoids (Tazorac)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

LIGHT

UVB

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Narrowband UVB

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

PUVA

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Grenz Ray

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Excimer Laser

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

SYSTEMIC

Oral retinoids (Soriatane, Tegison)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Methotrexate (Rheumatrex)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Cyclosporine (Neoral, Sandimmune)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Adalimumab (Humira)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Alefacept (Amevive)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Efalizumab (Raptiva)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Etanercept (Enbrel)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Infliximab (Remicade)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Ustekinumab (Stelara)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Golimumab (Simponi)

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

OTHER

Other - (please specify)

_____

Currently taking or Past

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Other - (please specify)

_____

Currently taking or Past

☐ Current ☐ Past

Length of time taking/taken (Months)

_____

Helped?

☐ A lot ☐ Some ☐ Not at all

Side Effects / Reactions

_____

Emotional Factors

Has there been a time in the last year when for most of the day, every day for at least two weeks you felt down, depressed, hopeless, or blue?

☐ Yes ☐ No

Has there been a time in the last year when for most of the day, every day for at least two weeks you felt little interest or pleasure in doing things you normally enjoy?

☐ Yes ☐ No

Have you ever been told by a doctor, nurse, or other health care professional that you had major (or clinical) depression

☐ Yes ☐ No

Have you ever been prescribed an anti-depressant medication such as Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine), Serzone (nefazodone), Effexor (venlafaxine), Elavil (amitriptyline), Tofranil (imipramine), nortriptyline, desipramine, etc.?

☐ Yes ☐ No

If Yes, did the medication help?

☐ Yes ☐ No

Have you ever been told by a doctor, nurse, or other health care professional that you had manic-depression or bipolar disorder?

☐ Yes ☐ No

Have you ever been prescribed a mood-stabilizing medication such as lithium, Tegretol (carbamazepine), or Depakote (divalproex)?

☐ Yes ☐ No

If Yes, did the medication help?

☐ Yes ☐ No

Has there been a time, lasting at least a month, when you were bothered by memories, dreams, or flashbacks of a traumatic event, or went out of your way to avoid reminders of the event?

☐ Yes ☐ No

Have you ever been told by a doctor, nurse, or other health care professional that you had post-traumatic stress disorder (PTSD)?

☐ Yes ☐ No

Have you ever been told by a doctor, nurse, or other health care professional that you had schizophrenia or schizoaffective disorder?

☐ Yes ☐ No

Have you ever been prescribed an anti-psychotic medication such as Haldol (haloperidol), Thorazine (chlorpromazine), Risperdal (risperidone), Zyprexa (olanzapine), Seroquel (quetiapine), Geodon (ziprazodone), etc.?

☐ Yes ☐ No

If Yes, did the medication help?

☐ Yes ☐ No

Have you ever been hospitalized for treatment of psychiatric or emotional problems?

☐ Yes ☐ No

On average, how many hours of sleep do you get per night? (Hours)

_____

Please rate your sleep 0 is 'Very Poor' while 7 is 'Like a Baby'

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Please rate your average level of life stress 0 is 'No Stress' while 7 is 'Extremely High'

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Please rate your average level of pain (not specific to psoriasis) 0 is 'No Pain' while 7 is 'Extremely High'

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Do you currently live alone?

☐ Yes ☐ No

Are you currently sexually active?

☐ Yes ☐ No

What is the average number of times per month that you are sexually active? (times/month)

_____

Are you currently using a form of birth control?

☐ Yes ☐ No

If Yes, are you currently taking birth control pills (oral contraceptives) ?

☐ Yes ☐ No

Please list your current method of birth control:

_____

Are you currently pregnant?

☐ Yes ☐ No

Are you currently breastfeeding?

☐ Yes ☐ No

Pain Today

Please rate your pain level today. Zero '0' is no pain and ten '10' is the worst imaginable pain

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Symptoms

Please select if you have experienced any of the following over the last month:

Back pain

☐ Yes ☐ No

Constipation

☐ Yes ☐ No

Cough

☐ Yes ☐ No

Dark or bloody stools

☐ Yes ☐ No

Diarrhea

☐ Yes ☐ No

Dizziness

☐ Yes ☐ No

Dry eyes

☐ Yes ☐ No

Dry mouth

☐ Yes ☐ No

Fainting spells

☐ Yes ☐ No

Fever

☐ Yes ☐ No

Gynecological (female) problems

☐ Yes ☐ No

Hand color changes in cold weather

☐ Yes ☐ No

Headaches

☐ Yes ☐ No

Heart pounding (palpitations)

☐ Yes ☐ No

Heartburn or stomach gas

☐ Yes ☐ No

Joint pain

☐ Yes ☐ No

Losing your balance

☐ Yes ☐ No

Loss of appetite

☐ Yes ☐ No

Loss of hair

☐ Yes ☐ No

Lump in your throat

☐ Yes ☐ No

Muscle pain, aches, or cramps

☐ Yes ☐ No

Muscle weakness

☐ Yes ☐ No

Nausea

☐ Yes ☐ No

Neck pain

☐ Yes ☐ No

Numbness or tingling of arms/legs

☐ Yes ☐ No

Pain in chest

☐ Yes ☐ No

Paralysis in arms or legs

☐ Yes ☐ No

Problems with hearing

☐ Yes ☐ No

Problems with memory

☐ Yes ☐ No

Problems with sleeping

☐ Yes ☐ No

Problems with smell or taste

☐ Yes ☐ No

Problems with thinking

☐ Yes ☐ No

Problems with urination

☐ Yes ☐ No

Ringing in the ears

☐ Yes ☐ No

Sexual problems

☐ Yes ☐ No

Shortness of breath

☐ Yes ☐ No

Skin rash or hives

☐ Yes ☐ No

Soaking night sweats

☐ Yes ☐ No

Sores in the mouth

☐ Yes ☐ No

Stomach pain or cramps

☐ Yes ☐ No

Stuffy nose

☐ Yes ☐ No

Sun-induced rash (not sunburn)

☐ Yes ☐ No

Swelling in ankles

☐ Yes ☐ No

Swelling in other joints

☐ Yes ☐ No

Swelling of hands

☐ Yes ☐ No

Swollen glands

☐ Yes ☐ No

Trouble swallowing

☐ Yes ☐ No

Unusual bruising or bleeding

☐ Yes ☐ No

Unusual fatigue

☐ Yes ☐ No

Use of drugs not sold in stores

☐ Yes ☐ No

Vomiting

☐ Yes ☐ No

Weight gain (> 10lbs)

☐ Yes ☐ No

Weight loss (< 10lbs)

☐ Yes ☐ No

Wheezing

☐ Yes ☐ No

Please select "Current" for medication(s) you are Currently Taking and Please select "Past" for medication(s) you have taken in the Past. Please fill all that apply.

Beta-blockers

☐ Current ☐ Past

ACE Inhibitors

☐ Current ☐ Past

Interferon

☐ Current ☐ Past

Corticosteroids

☐ Current ☐ Past

Gold salts

☐ Current ☐ Past

Anti-inflammatory drugs

☐ Current ☐ Past

Antimalarials

☐ Current ☐ Past

Lithium

☐ Current ☐ Past

Allergies to medications (Please include reaction)

Allergic to latex

☐ Yes ☐ No

Allergic to lidocaine

☐ Yes ☐ No

Please list any current allergies and type of reaction

1. Allergy

_____

Reaction

_____

2. Allergy

_____

Reaction

_____

3. Allergy

_____

Reaction

_____

Have you received the following vaccines:

1. Pneumonia vaccine?

☐ Yes ☐ No

Year of last vaccination? (Year)

_____

2. Influenza (Flu) vaccine?

☐ Yes ☐ No

Year of last vaccination? (Year)

_____

Other Conditions

Do you or any blood relatives currently have or have had in the past any of the following medical conditions?

ALOPECIA AREATA

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

ANGINA

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

ANKYLOSING SPONDYLITIS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

ANXIETY

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

AUTOIMMUNE DISEASE/DISORDER

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

CANCER

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

CELIAC DISEASE

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

CONGESTIVE HEART FAILURE

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

CROHN'S DISEASE/ULCERATIVE COLITIS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

DEPRESSION

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

DERMATOMYOSITIS/POLYMYOSITIS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

DIABETES

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

ECZEMA (OR ATOPIC DERMATITIS)

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

ENDOCRINE DISEASE

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

EYE DISEASE/DISORDER

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

HASHIMOTO'S OR GRAVES' THYROIDITIS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

HEART ATTACK

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

HEPATIC (LIVER) DISEASE/DISORDER

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

HEPATITIS/JAUNDICE

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

HIGH CHOLESTEROL

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

HIGH TRIGLYCERIDES

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

HIV/AIDS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

HYPERTENSION

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

LUPUS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

MULTIPLE SCLEROSIS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

MUSCLE OR BONE DISEASE/DISORDER

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

MYASTHENIA GRAVIS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

NEUROLOGIC DISEASE/DISORDER

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

OBESITY

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

EAR, NOSE, OR THROAT DISEASE/DISORDER

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

POLYMYALGIA RHEUMATICA

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

BIPOLAR DISEASE (MANIC DEPRESSION)

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

RECURRENT 'STREP THROAT'

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

RENAL (KIDNEY) DISEASE/DISORDER

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

RESPIRATORY DISEASE/DISORDER

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

RHEUMATOID ARTHRITIS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

SCLERODERMA

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

SEBORRHEIC DERMATITIS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

SEIZURE

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

SJOGREN'S DISEASE

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

SKIN CANCER

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

SKIN DISEASE OTHER THAN PSORIASIS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

STROKE

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

TEMPORAL ARTERITIS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

THYROID DISEASE/DISORDER

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

TRANSPLANT

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

UVEITIS

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

VITILIGO

Self

☐ Yes ☐ No

Family

☐ Yes ☐ No

General Health

1. In general, would you say your health is:

(please select)

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. The following questions are about activities you might do during a typical day. DOES YOUR HEALTH NOW LIMIT YOU in the activities? If so, how much?

a. MODERATE ACTIVITIES, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf

☐ Yes, Limited A Lot ☐ Yes, Limited A Little ☐ No, Not Limited At All

b. Climbing several flights of stairs

☐ Yes, Limited A Lot ☐ Yes, Limited A Little ☐ No, Not Limited At All

3. During the PAST 4 WEEKS, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

a. ACCOMPLISHED less than you would like

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

b. Were limited in the KIND of work or other activities

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

a. ACCOMPLISHED less than you would like

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

b. Did work or other activities LESS CAREFULLY THAN USUAL

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

5. During the PAST 4 WEEKS, how much did pain interfere with your normal work (including both work outside the home and housework)?

(please select)

☐ Not at All ☐ A Little bit ☐ Moderately ☐ Quite a Bit ☐ Extremely

6. These questions are about how you feel and how things have been with you DURING THE PAST 4 WEEKS. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the PAST 4 WEEKSâ€¦

a. Have you felt calm and peaceful?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

b. Did you have a lot of energy?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

c. Have you felt downhearted and depressed?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

7. During the PAST 4 WEEKS, how much of the time has your PHYSICAL HEALTH OR EMOTIONAL problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(please select)

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Please answer each of the following questions as they pertain to your psoriasis DURING THE PAST MONTH.

How self-conscious do you feel with regard to your psoriasis? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How helpless do you feel with regard to your psoriasis? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How embarrassed do you feel with regard to you psoriasis? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How angry or frustrated do you feel with regard to your psoriasis? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

To what extent does your psoriasis make your appearance unsightly? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How disfiguring is your psoriasis? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How much does your psoriasis impact your overall emotional well-being? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Overall, to what extent does your psoriasis interfere with your capacity to enjoy life? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How much have each of the following been affected by your psoriasis during the past month.

Itching? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Physical irritation? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Physical pain or soreness? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Choice of clothing to conceal psoriasis? Not at All = 0,Very Much = 10

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Thanks for completing the survey. Please click on the "Save" button. You will be directed to another page that will provide you with a validation code. Please remember this code. You will need this code to return to your survey. Please do NOT click on the "Next" button.

STOP! Do NOT click on the "Submit" button.