Metrolina Dermatology
and Skin Surgery Specialists

Psoriasis Biologic Questionnaire

Patient Name: _____
Weight: _____
Date: _____

Yes No

___ ___ Do you consume alcoholic beverages? If so, how much/how often: _____
___ ___ Do you smoke? If so, how much/how often: _____
___ ___ History of liver problems /hepatitis?
___ ___ History of kidney problems /dialysis?
___ ___ History of heart disease?
___ ___ History of depression?
___ ___ Do you have high cholesterol?
___ ___ Do you have neurological problems, such as multiple sclerosis?
___ ___ Do you optic neuritis or loss of vision in one/both eyes?
___ ___ History of cancer (skin or internal)? If yes, describe: _____
___ ___ Family history of cancer (skin or internal)? If yes, describe: _____
___ ___ Tuberculosis exposure/positive TB skin test?
___ ___ TB skin test within 1 year? Date: _____
___ ___ Do you have Crohn's disease or ulcerative colitis?
___ ___ History of T cell lymphoma?
___ ___ Are you a female of childbearing age? If yes, what method of contraception do you use: _____
___ ___ Do you smoke?

Please mark any of the following treatments that you have used in the past for your psoriasis and list the length of treatment with dates:

Yes No
___ ___ Light therapy: _____
___ ___ PUVA: _____
___ ___ Methotrexate: _____
___ ___ Oral /injectable steroids: _____
___ ___ Soriatane: _____
___ ___ Cyclosporine: _____
___ ___ Enbrel: _____
___ ___ Humira: _____
___ ___ Remicade: _____
___ ___ Stelara: _____
___ ___ Topical steroids? Length of treatment: _____

Circle the topical steroids below that you have used:

Triamcinolone	Clobetasol	Fluocinonide	Fluocinolone
Betamethasone	Halobetasol	Desonide	Alclometasone

Other treatments tried: _____

Patient Self-Assessment Name: _____ Date: _____

Part 1: Quality of Life - Please answer each of the following questions as they pertain to your psoriasis during the past month. (Circle one number per question)

	Not at All					Somewhat					Very Much
1. How self-conscious do you feel with regard to your psoriasis?	0	1	2	3	4	5	6	7	8	9	10
2. How helpless do you feel with regard to your psoriasis?	0	1	2	3	4	5	6	7	8	9	10
3. How embarrassed do you feel with regard to your psoriasis?	0	1	2	3	4	5	6	7	8	9	10
4. How angry or frustrated do you feel with regard to your psoriasis?	0	1	2	3	4	5	6	7	8	9	10
5. To what extent does your psoriasis make your appearance unsightly?	0	1	2	3	4	5	6	7	8	9	10
6. How disfiguring is your psoriasis?	0	1	2	3	4	5	6	7	8	9	10
7. How much does your psoriasis impact your overall emotional well-being?	0	1	2	3	4	5	6	7	8	9	10
8. Overall, to what extent does your psoriasis interfere with your capacity to enjoy life?	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? (Circle one number per question)

	Not at All					Somewhat					Very Much
9. Itching?	0	1	2	3	4	5	6	7	8	9	10
10. Physical irritation?	0	1	2	3	4	5	6	7	8	9	10
11. Physical pain or soreness?	0	1	2	3	4	5	6	7	8	9	10
12. Choice of clothing to conceal psoriasis?	0	1	2	3	4	5	6	7	8	9	10

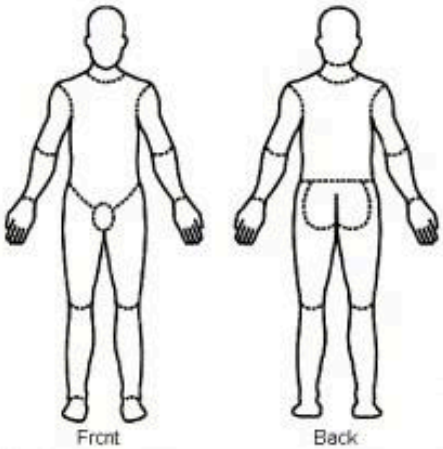
Total Quality-of-Life Score (0 - 120) ^ _____

^ (Medical staff to calculate)

12-item Psoriasis Quality of Life Questionnaire (PSQOL-12), Copyright 2002, 2003, Allergan, Inc.

Part 2:

A. Using the figures below, place an "X" on the parts of your body that currently have psoriasis.



Front Back

Part 3:

A. Have you ever been diagnosed with psoriatic arthritis?
Yes ☐ No ☐

B. Do you have swollen, tender, or stiff joints (e.g., hands, feet, hips, back)?
Yes ☐ No ☐

If yes, how many joints are affected? (Check one box)
1 ☐ 2 ☐ 3 ☐ 4 ☐ More than 4 ☐

If yes, how much have your joint symptoms affected your daily activities?
Not at all ☐ A little ☐ A lot ☐ Very much ☐

STOP Once completed, please return to medical staff