



PSORIASIS CLINIC

Date: / / S. No.:
Name: Age: Sex:
File No.: Nationality:
Address/Tel.: Married Unmarried
Diagnosis:
Referring Doctor:..... Referring Center:.....

Duration of Disease:

Age of Onset:

Site at Onset:

Progression of Disease: Insidious Rapid Stationary

Severity of Disease: Mild Moderate Severe

Arthropathy: +ve -ve

Precipitating or Aggravating Factors if Any:

Stress Drugs Season Foods

Physical Trauma Pregnancy Hormones

Smoking Alcohol Others

If +ve specify:
.....

Past History:
.....

Associated Diseases: Diabetes Mellitus Hypertension TB
 Malignancy Autoimmune disease Others:

Previous Treatment:
 Topical:.....
.....

Systemic: Retinoids / Methotrexate / Cyclosporine A / PUVA / UVB / Steroids / Others

Family History: +ve -ve

(If +ve specify): First degree
 Second degree
 Third degree

Base Line Investigations:

1. CBC: Not done Normal N.A.
 Abnormal findings:
2. Serum Biochemistry/
Liver / Renal: Not done Normal N.A.
 Abnormal findings:
3. Urine R/E and M/E: Not done Normal N.A.
 Abnormal findings:
4. Stool Routine: Not done Normal N.A.
 Abnormal findings:
5. X-ray chest: Not done Normal N.A.
 Abnormal findings:
6. Eye Examination
(Slit lamp/ Fundus): Not done Normal N.A.
 Abnormal findings:
7. HLA Typing: Not done Done
 Findings:
8. ABO Grouping: Not done Done
 Findings:
9. Rhumatoid Factor: Not done Done
 Findings:
10. Skin biopsy: Not done Done Biopsy No.: Date:/...../.....
 Findings:
- 11- Others:

Treatment

Date of 1st. Treatment at this Center:/ /

Topical:

Systemic:

FOLLOW UP (QUARTERLY ASSESSMENT)

S.No	Date	Clinical	Sig. Invest.	Side Effects	Remarks