EXPOSURE QUESTIONNAIRE

Loma Linda Dermatology

Instructions to respondents:

- Please mark an “X” in only one box unless otherwise stated in the question.
- Specific instructions are in *italics* within each question.

1. Gender:

☐ male ☐ female

2. Ethnicity:

☐ hispanic ☐ african american ☐ caucasian ☐ asian ☐ pacific islander
☐ other ________________

3. Age: ________________

4. Please list all medications taken over the past year (*attach separate sheet if required*)
(*include all prescription, over-the-counter products, vitamins, and herbal supplements*)

Current Medications		Past Medications		
Medication	**Start date**	**Medication**	**Start date**	**Stop date**

5. Do you have allergies to any medications?

no ☐ 1
yes ☐ 2 What?____

6. Date of onset of rash: __________________ Site of onset: ________________________________
Description of rash: ____
____

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7. What do you think is/was the cause of your skin rash? (describe onset)

____

____

8. What is your occupation? ______________________ Since when? ___________ *(year)*
What is your major activity at work? _______________________________________

____

9. Do you have hobbies or past time activities?

No ☐ 1

Yes ☐ 2 What kind of work/activities? ___________________________

____

____

10. Have you ever had "hay fever" or other symptoms of nasal allergy? *(bouts of sneezing, itchy or runny nose from pollens or animals, etc.)*

☐ 1 no ☐ 2 yes ☐ 0 don't know

11. Have you ever had asthma?

☐ 1 no

☐ 2 yes. If yes, was it diagnosed by a doctor? no ☐ 1 yes ☐ 2 When?________ *(year)*

☐ 0 don't know

12. Does anyone in your family have any of the following conditions?

Asthma	☐ yes	☐ no
Hay fever/ seasonal allergies	☐ yes	☐ no
Eczema/atopic dermatitis	☐ yes	☐ no

13. Was the allergy/ were the allergies diagnosed with…. *(mark any that are applicable)*

patch-test *(test are normally taped onto the upper back and removed after 1-2 days)* ☐ 2

skin-prick-*tests* *(tests drops are normally placed on the forearm and pricked through with lancets or needles. The results are read after 15-30 minutes.)* ☐ 2

blood tests *(e.g., RAST tests)* ☐ 2

other, what?____ ☐ 2

don't know ☐ 0

18. Have you noticed that contact with certain materials, chemicals or anything else makes

your rash worse? *(one answer in each column if applicable)*

☐ 1 no

☐ 2 yes What? ____________________

19. How many times do you wash your hands during a usual working day? *(include hand washing during your work and at home/outside work)*

0-5 times per day	☐ 3	6-10 times per day	☐ 4
11-20 times per day	☐ 5	more than 20 times per day	☐ 6

20. What type of gloves do you (or did you) use in your work/hobbies? (*mark any that are applicable in each column)*

	At present	Only previously
natural rubber/latex	☐ 2	☐ 3
synthetic rubber (e.g. nitrile, neoprene, etc)	☐ 2	☐ 3
plastic (e.g. vinyl, PVC, polyethene)	☐ 2	☐ 3
cotton gloves underneath rubber or plastic gloves	☐ 2	☐ 3
leather	☐ 2	☐ 3
cloth other, what?____________	☐ 2	☐ 3
don't know	☐ 0	☐ 0

21. Does your rash improve when you are away from your normal work (for example, weekends or longer periods)?

☐ 1 no ☐ 2 yes, sometimes ☐ 3 yes, usually ☐ 0 don't know

24. Review of systems (*please mark all that apply*)

CONSTITUTIONAL SYMPTOMS

☐ none

☐ unintentional weight loss

☐ fever

☐ special diet

☐ other: ____________

RESPIRATORY

☐ normal

☐ asthma

☐ other: ____________

CARDIOVASCULAR

☐ normal

☐ angina

☐ hypertension

☐ heart attack

☐ artificial heart valve

☐ other: ____________

NEUROLOGICAL

☐ normal

☐ strokes

☐ seizures

☐ other: ____________

SKIN

☐ normal

☐ keloids

☐ poor healing

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☐ other: _______________

PSYCHIATRIC

☐ normal

☐ depression

☐ anxiety attacks

☐ other: _______________

HEMATOLOGIC/ LYMPHATIC

☐ normal

☐ anemia (low blood count)

☐ other: _______________

GASTROINTESTINAL

☐ normal

☐ stomach ulcer

☐ other: _______________

ENDOCRINE

☐ normal

☐ diabetes

☐ thyroid problems

EYES / EARS / NOSE / THROAT

☐ normal

☐ glaucoma

☐ hearing aid

☐ cosmetic surgery

MUSCULOSKELETAL

☐ normal

☐ arthritis (joint pain)

☐ artificial joint

Is yourphysical activity limited?

☐ yes ☐ no

____

____

____

____

(*please describe*)

INFECTIONS

☐ none

☐ hepatitis

☐ HIV/AIDS

☐ tuberculosisi (TB)

☐ other: ______________

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25. Please list all topical medications used over the past year
(*include all prescription, over-the-counter products, vitamins, and herbal supplements*)

Current Medications	Past Medications

(*attach separate sheet if required*)

26. Please list all your personal care and cosmetic products
(*be as specific as possible*)

Soap	
Body lotion	
Hand lotion	
Facial makeup	
Base	
Blush	
Eye products	
Eyelash curler	
Lipstick	
Deodorant	
Cologne, perfume	
Shaving cream	
Hair dye, bleach, etc.	
Laundry detergent	
Nail cosmetics, wraps	
Toothpaste	
Contact lenses	
Shampoo	
Other	

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Reference : Crawford, G. Contact Dermatitis Exposure Questionnaire. 2004