

# ECZEMA ASSESSMENT

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

This form helps your physician understand how eczema has affected you/your child in the past few months. Please fill it out as accurately as possible. There are no right or wrong answers, and any information you provide is confidential. Circle the number that most closely matches your situation.

1. How often do you/your child have the rash/eczema?

Yearly 1 | Every few months 2 | Monthly 3 | Weekly 4 | Daily 5

2. How often do you/your child itch from eczema?

Never 0 | Rarely 1 | Sometimes 2 | Often 3 | All the time 4

3. How often does eczema interfere with sleep?

Never 0 | Rarely 1 | Sometimes 2 | Often 3 | All the time 4

4. How often does having eczema interfere with work, school, or recreational activities?

Never 0 | Rarely 1 | Sometimes 2 | Often 3 | All the time 4

5. How often does having eczema affect daily friendships, social life, or family/friend gatherings?

Never 0 | Rarely 1 | Sometimes 2 | Often 3 | All the time 4

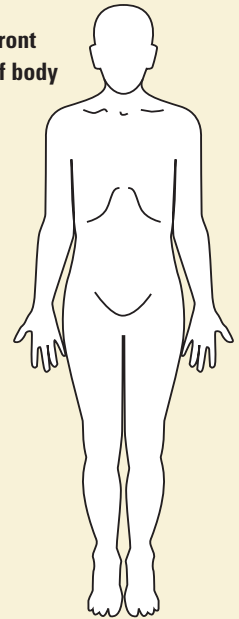
6. How often does having eczema make you/your child sad, embarrassed, or upset?

Never 0 | Rarely 1 | Sometimes 2 | Often 3 | All the time 4

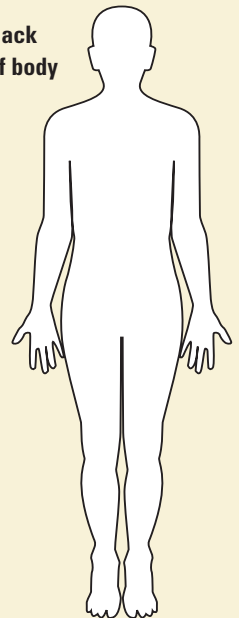
**Body Surface Area**

Please shade the areas where you have recently experienced eczema.

Front  
of body



Back  
of body



**Score: add score for each component above (maximum of 25)**

1-8 Mild

9-16 Moderate

17-25 Severe

\_\_\_\_\_ Total Score

Please provide any additional information or comments on the impact eczema has on your life.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*If additional space is needed, please write on back of page.*