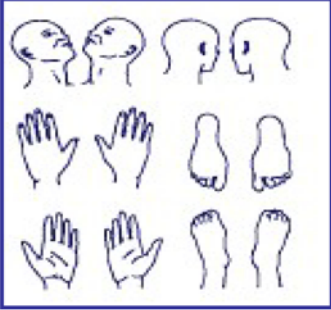


Current Complaint:

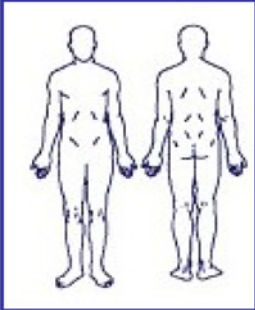


Date of onset and/or duration: _____

At onset: Area(s) affected _____

Severity: Mild Moderate Severe

Type and pattern of eruption: _____



Now: Area(s) affected _____

Severity: Mild Moderate Severe

Currently: Stable Increasing Decreasing Unclear

Worsens: During work week After weekend

Improves: After weekend After holidays/vacations

Outbreaks Occur: Annually Seasonally Monthly Unclear

Previous Outbreaks: No Yes Date(s): _____

Self-Treat: No Yes Date(s): _____

Physician Treatment: No Yes Date(s): _____

History of allergic disorders:

Asthma Hay fever Childhood eczema Urticaria

Food allergy: Known Suspected Type _____

Other known allergies: Nickel/metals Flowers/Trees/Grasses Perfume/fragrance Latex (type I)

Insects Medicines Rubber Animals

Other _____

Suspected allergies: _____

Previous drug reactions: None Yes (drug/date) _____

Family history of allergies and asthma: Yes No Hay fever: Yes No Eczema: Yes No

Relationship (name) _____ Disease (name) _____

Relationship (name) _____ Disease (name) _____

Home Environment:

Home Apartment/Condo Constructed after 1980? Yes No

Renovated since 1980? Yes No Location: Suburban Urban Rural

Other location: _____ Lived there since: _____

Pets: None Cats Dogs Birds Rodents Livestock: _____ Other _____

Current animal contact: Daily Rare Occasional Pets in house? Yes No

Pets/animals as a child? None Type: _____ Contact: Rare Frequent

Symptoms around animals: No Yes Describe: _____

Housecleaning frequency: Daily Weekly Monthly Occasionally Rarely

Participate in housecleaning: Never Always Occasionally Rarely

Equipment/Materials used: _____

Help with laundry? Never Daily Weekly Occasionally Detergent: _____

Symptoms at home: No Yes Describe: _____

Sports/Hobbies:

golf tennis/raquetball woodworking computers baseball sewing

football skiing knitting/needlework paper crafts ceramics piano

painting guitar running/hiking home repairs basketball photography

other _____

Frequency: Daily Few times weekly Weekends only Rarely Duration: _____

Equipment/Materials used: _____

Symptoms with sports/hobbies: No Yes Describe: _____

Personal Care: Handwashing frequency: _____ Soap type: _____
 Bathing frequency: _____ Soap type: _____
 Deodorant use/frequency: _____ Deodorant type: _____
 Lotion use/frequency: _____ Creme use/frequency: _____
 Cologne/perfume use/frequency: _____ Aftershave use/frequency: _____
 Shaving cream use/frequency: _____ Hair coloring use/frequency: _____
 Toothpaste use/frequency: _____ Mouthwash use/frequency: _____
 Shampoo use/frequency: _____ Conditioner use/frequency: _____
 Hair styling aids use/ frequency: _____ Nail conditioner/remover use/frequency: _____
 Nails polish use/frequency: _____ Artificial nail use/frequency: _____
 Contact lenses: _____ Saline/cleaner: _____

Makeup Use: Foundation/base Blush Eyelid powder Eyeliner Mascara Remover
 Lipstick/gloss/liner Concealer Face Powder Other: _____

Facials: Toner/Astringent Masque Moisturizer/Cream Cleanser Other _____

Condoms/diaphragms: Daily Weekly Monthly Occasionally Don't use
Type: _____

Other personal care products use/ frequency: _____
Symptoms with personal care: _____

Jewelry & Tattoos: Wear Daily Few times each week Weekends Rarely Never
Jewelry type Earring(s) Ring(s) Bracelet(s) Watch(s) Necklace(s)
 Piercing(s): _____
Tatoos: Recent Old Permanent Temporary Henna-based
Symptoms with jewelry/tatoos: _____

Employment history: Current employer: _____ Since (date): _____
Job title: _____ Since (date): _____
Job description: _____
Employer at onset of dermatitis: _____
Previous job description and duration: _____

Previous / current contact: Metals Dust Vibration Cold/heat Fibers
 Chemicals Fumes Other: _____

Work Environment: Office Factory Hospital Construction site Farming Laboratory
 Indoors Outdoors Other _____

Work Equipment: Gloves Boots Apron Mask/respirator Face shield Head cover
 Badge Monitors Overalls Other _____

Symptoms at work: _____ Since (date): _____
Description of work when rash began: _____
Materials used at work: _____
 Treat and/or document at place of employment: _____
Effect of weekends/holidays/vacations Same Improves Worsens
Loss of work: No Yes, on dates: _____ Other workers with same problem? No Yes
Previous compensation claims: No Yes, for _____
 Part-time or Second job: No Yes, as: _____
2nd job description: _____

Work Environment: Office Factory Hospital Construction site Farming Laboratory
 Indoors Outdoors Other _____

Symptoms at 2nd job: same as above different: _____ Since (date): _____

Consent for Patch/Photopatch Testing

I hereby give my consent and authorize Dr. Jonathan Zippin and Weill Cornell Medical College ("Hospital") and its staff to perform the following procedure ("procedure") upon _____ (name of patient). I understand that for patch testing I will have allergens applied to my back for 1-2 days. Expected side effects of this procedure include but are not limited to itching, pain, and skin rash. I understand that for photopatch testing, in addition to the above, I will be treated using an ultraviolet phototherapy lamp unit ("device"). I understand that, as with natural sunlight, use of the device may cause adverse effects, including, but not limited to: premature aging of the skin, skin cancer and skin burns. I understand that I, and all other persons who are in the room, need to wear ultraviolet protective eyewear when the device is being operated, and that failure to do so may result in severe burns and long term injury to the eyes.

Dr. Jonathan Zippin has explained to me, in a way I understand, the following:

1. The nature, purpose and the reasonably foreseeable risks of the procedure, including but not limited to: localized flare of dermatitis and other skin disorders, scarring as a result of strong allergic reactions, inadvertent sensitization to patch materials, mechanical or radiation injury due to improper use of light sources, discomfort at patch test sites and "flares" at previously involved sites, hyperpigmentation, and anaphylaxis on very rare occasions.
2. The alternatives to the procedure; including not performing the procedure, as well as the risks and benefits of the alternatives;
3. That the practice of medicine is not an exact science and the procedure may not result in the intended benefits;
4. That there are risks associated generally with medical procedures and treatments not ordinarily anticipated which can cause adverse consequences to my life or health; and
5. That other practitioners may assist with the procedure(s) as necessary, and may perform important tasks related to the procedure.

By signing below, I confirm that I fully understand the information provided to me, my questions have been answered, and I give my consent to the procedure specified above. I further grant permission for the use of such tissues and/or organs as it may be necessary to remove during the procedure for purposes of pathological diagnosis and thereafter for the advancement of medical science and education, and their disposal, at this Hospital or at such other institution as this Hospital may designate.

_____/_____/_____
(Patient/HealthCare Agent/Guardian/Family Signature) (Printed Name) (Relationship to Patient) (Date) (Time)

By initializing here I consent to the use of film or recording of the procedure for internal education/performance improvement purposes.

_____/_____/_____
(Patient/HealthCare Agent Signature) (Printed Name) (Date) (Time)

Mark this box if telephone consent Mark this box if interpreter was involved

I have discussed the nature and purpose and the reasonably foreseeable risks and benefits of the procedure, the alternatives, including not performing the procedure, as well as the risks and benefits of the alternatives; and I am satisfied that the patient or the patient's legal representative who signed above understands them.

(Signature of Physician / Appropriately Credentialed Practitioner Providing Explanation) (M.D. ID Code)