

ICHTHYOSIS EXAMINATION FORM

PERSONAL DATA

Name: _____

Mother: _____

Father: _____

Further (affected/unaffected) relatives:

Consanguinity? Yes No

If yes, which grade? _____

DOB: _____

Place of birth: _____

Address: _____

GENERAL MEDICAL HISTORY

1. Severe medical problems in the past:

2. Allergies/drug allergies:

3. Family history:

a. Skin problems

b. Others

MDC Berlin

Index:

Sample:

Sample:

Sample:

Sample:

Sample:

Sample:

SKIN DISEASE HISTORY

General history of skin diseases:

Specific questions:

1. Collodion baby	Yes	No	Unknown
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2. Sweating abnormalities If yes, please specify	Yes	No	Unknown
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3. Infection history If yes, please specify	Yes	No	Unknown
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4. History of blisters If yes, please specify	Yes	No	Unknown
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5. Dermatological medications prescribed (When? For how long? Dose?)

a. Topical

b. Systemic

DERMATOLOGICAL EXAMINATION

General description of the skin findings:

Specific items:

1. Scalp involvement:
If yes, please specify

Yes

No

2. Face involvement:
If yes, please specify

Yes

No

3. Lips involvement:
If yes, please specify

Yes

No

4. Eye involvement:
If yes, please specify

Yes

No

5. Ear involvement:
If yes, please specify

Yes

No

6. Extensor involvement:

None

Mild

Moderate

Severe

7. Flexor involvement:

None

Mild

Moderate

Severe

8. Palms involvement:
If yes, please specify

Yes

No

Hyperkeratosis:
Pits present

None

Mild

Moderate

Severe

Yes

No

9. Soles involvement:
If yes, please specify

Yes

No

Hyperkeratosis:
Pits present

None

Mild

Moderate

Severe

Yes

No

10. Genital involvement:
If yes, please specify

Yes

No

11. Scale type:

- | | | | | | | | | |
|--------------------|---|--------------|------|---|--------|---|---|------------|
| a. Thick/bark-like | < | 1 | 2 | 3 | 4 | 5 | > | Fine/scaly |
| b. Color: | | White | Gray | | Yellow | | | Brown |
| c. Adherent | | Non-adherent | | | | | | |
| d. Crusty | | Non-crusty | | | | | | |

e. Special type: _____

- | | | | | |
|----------------------|------|------|----------|--------|
| 12. Visible erythema | | Yes | | No |
| If yes, on face: | None | Mild | Moderate | Severe |
| extremities: | None | Mild | Moderate | Severe |
| torso: | None | Mild | Moderate | Severe |

- | | | |
|------------------------|-----|----|
| 13. Blisters | Yes | No |
| If yes, please specify | | |
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- | | | |
|------------------------|-----|----|
| 14. Skin infection | Yes | No |
| If yes, please specify | | |
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- | | | |
|-------------------------------|-----|----|
| 15. Nail abnormality present: | Yes | No |
| If yes, please specify | | |
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- | | | | | |
|-----------------------------|------|------|----------|--------|
| 16. Hair | | | | |
| Scalp Hair Loss | None | Mild | Moderate | Severe |
| Body Hair Loss | None | Mild | Moderate | Severe |
| Hirsutism | None | Mild | Moderate | Severe |
| Hair structure abnormality? | Yes | | No | |
| If yes, please specify | | | | |
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- | | | |
|-------------------|-----|----|
| 17. Specific odor | Yes | No |
|-------------------|-----|----|

18. Further observations/remarks

Name of physician: _____

Date: _____