SAN TAN Allergy & Asthma
ECZEMA CLINIC
4915 E. Baseline Road Suite 112
Gilbert, AZ 85234
Ph (480) 626–6600 Fax (480) 626–6604

S. Reed Shimamoto, MD ● Neal Jain, MD ● Jennifer Hill, MD

NAME (Last, First, M.I)	**DOB:**

When was the patient first diagnosed with eczema (atopic dermatitis)? _____

Please indicate the date and performing office if any of the following tests have been performed:

□ **Environmental Skin Testing**
Approximate date testing was performed: _____

Physician: _____

Phone number: _____ Fax:_____

Address: _____

Please ensure your records have been sent to our office **prior to your appointment date**

□ **Food Allergy Skin Testing**
Approximate date testing was performed: _____

Physician: _____

Phone number: _____ Fax:_____

Address: _____

Please ensure your records have been sent to our office **prior to your appointment date**

□ **Patch Testing**
Approximate date testing was performed: _____

Physician: _____

Phone number: _____ Fax:_____

Address: _____

Please ensure your records have been sent to our office **prior to your appointment date**

□ **Skin Biopsy**
Approximate date testing was performed: _____

Physician: _____

Phone number: _____ Fax:_____

Address: _____

Please ensure your records have been sent to our office **prior to your appointment date**

All relevant records must be received by our office **prior** to your appointment. If you are completing this paperwork prior to your appointment and would like us to request your records from any of the above physicians, please sign and date below.

_____ _____

Signature of parent/guardian Date

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NAME (Last, First, M.I)	**DOB:**

Have you (or your child) ever been treated for a skin infection or given antibiotics to treat your eczema? YES / NO

Please indicate which, if any, topical eczema therapies you (or your child) have used before:

Low Potency Corticosteroids		
Medication	Duration of Use	Did you respond to treatment?
Hydrocortisone		
Aclometasone diproprionate		
Desonide		
Flucinolone acetonide		
Mid-Potency Corticosteroids		
Medication	Duration of Use	Did you respond to treatment?
Fluticasone propionate		
Fluocinolone acetonide cream		
Betamethasone valerate		
Mometasone furoate cream		
Triamcinolone acetonide		
High Potency Corticosteroids		
Medication	Duration of Use	Did you respond to treatment?
Betamethasone diproprionate		
Mometasone furoate ointment		
Clobetasol		
Halobeasol propionate		
Fluocinolone acetonide ointment		
Topical Calcineurin Inhibitors		
Medication	Duration of Use	Did you respond to treatment?
Protopic (Tacrolimus)		
Elidel (Pimecrolimus)		
PDE-4 Inhibitor		
Medication	Duration of Use	Did you respond to treatment?
Eucrissa (Crisaborole)		

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NAME (Last, First, M.I)	**DOB:**

If you have used a medication for eczema which was not listed on the last page, please list it here. _____

_____

_____

What non-medicated topical moisturizers have you (or your child) used? _____

_____

Do you use any homeopathic topical treatments or essential oils on your (or your child's) skin? If so, list below:

_____

_____

Please indicate which, if any, oral immune suppressant medication therapies you (or your child) have used before:

Medication	Duration of Use	Did you respond to treatment?
Cyclosporine		
Methotrexate		
Azathioprine		
Mycophenolate mofetil		
Prednisone or other systemic corticosteroids		

Have you (or your child) ever been treated with a biologic therapy such as Dupixent (dupilumab) or Xolair (omalizumab)?

Medication	Duration of Use	Did you respond to treatment?
Dupixent (dupilumab)		
Xolair (omalizumab)		

How frequently do you (or your child) take baths? How long do you soak? _____

Please indicate what bath products you use:

a. Soap: _____
b. Shampoo: _____
c. Conditioner: _____
d. Bath Additives: _____

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NAME (Last, First, M.I)	**DOB:**

Please list any diagnosed food allergies:

Food	Reaction to food

Which food(s) do you (or your child) currently avoid? _____
_____

Are you interested in participating in clinical trials? YES / NO