Psoriasis Patient Information Form

For Women with Psoriasis and Comorbidities

Please answer the questions below as accurately as possible to help personalise your treatment plan to your psoriasis and your daily life.

Full name: --

Date: --

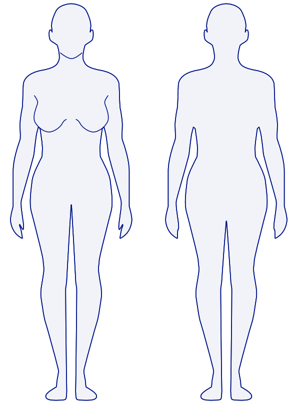
Age: --

Year of first psoriasis symptom: --

Year of first diagnosis: --

1 **Please indicate the areas where your psoriasis lesions bother you:**

Select all that apply on the body maps to the right.



2 **Which aspect of your psoriasis bothers you the most?**

Please tick all boxes that apply.

- ☐ Itchiness
- ☐ Sensitive areas e.g. genital area
- ☐ Appearance
- ☐ Other

If "Other", please state what bothers you most below.

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3 **How much does your psoriasis affect your life?**

Select your response on the scale from 0–10.

Not at all 0 1 2 3 4 5 6 7 8 9 10 Severely

4 **Are you satisfied with your current treatment?**

Select your response on the scale from 0–10.

Not at all 0 1 2 3 4 5 6 7 8 9 10 Yes, very

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5 How well do you tolerate your current treatment?

Please tick the appropriate response.

- ☐ Well tolerated
- ☐ Minor side effects
- ☐ Major side effects
- ☐ Severe side effects

If "Minor/Major/Severe side effects", have these side effects been reported?

- ☐ Yes
- ☐ No

6 Have you experienced any of the following?

Please tick all boxes that apply.

- ☐ Joint pain
- ☐ Depressed mood
- ☐ Fatigue/tiredness/sleeping difficulties
- ☐ Low self-esteem or body confidence
- ☐ Unexplained or unintentional weight loss
- ☐ Sexual dysfunction/problems
- ☐ Abdominal pain or symptoms, e.g. blood in stools, diarrhoea lasting longer than 2 weeks

7 Do you have a family history of any of the following?

Please tick all boxes that apply.

- ☐ Inflammatory bowel disease, e.g. ulcerative colitis, Crohn's disease
- ☐ Cardiovascular diseases at a young age (<60 years), e.g. stroke, heart attack
- ☐ Diabetes
- ☐ Mental health conditions e.g. anxiety, depression
- ☐ Psoriatic Arthritis

8 How many days a week do you consume alcohol?

Please tick the appropriate response.

- ☐ 0
- ☐ 1–2
- ☐ 3–4
- ☐ 5–7

On the day(s) that you consume alcohol, how many drinks do you have?

Please tick the appropriate response.

- ☐ 1–2
- ☐ 3–4
- ☐ 5–7
- ☐ 7+

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9 How many days a week do you exercise for more than 30 minutes?

Please tick the appropriate response.

- ☐ 0
- ☐ 1–2
- ☐ 3–4
- ☐ 5–7

10 How often do you smoke?

Please tick the appropriate response.

- ☐ Never
- ☐ Less than once a week
- ☐ At least once a week
- ☐ At least once a day

11 Do you have a healthy, balanced diet? e.g. fruit and vegetables, high variety, low sugar

Please tick the appropriate response.

- ☐ Yes
- ☐ Mostly
- ☐ Mostly not
- ☐ No

12 If you are of fertile age, do you plan to start a family?

Please tick the appropriate response.

- ☐ Yes, in the next year
- ☐ Yes, in the next five years
- ☐ Unsure
- ☐ No

13 Do you have any concerns about the impact of your psoriasis, or your treatment for psoriasis on starting a family?

Please tick the appropriate response.

- ☐ Yes
- ☐ No

If "Yes", please state what bothers you most below.

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