Tufts Medical Center

Department of Dermatology
Contact Dermatitis Clinic
Phone: 617-636-0156
Fax: 617-636-9169
dermpatch@tuftsmedicalcenter.org

Patch Test Patient Form

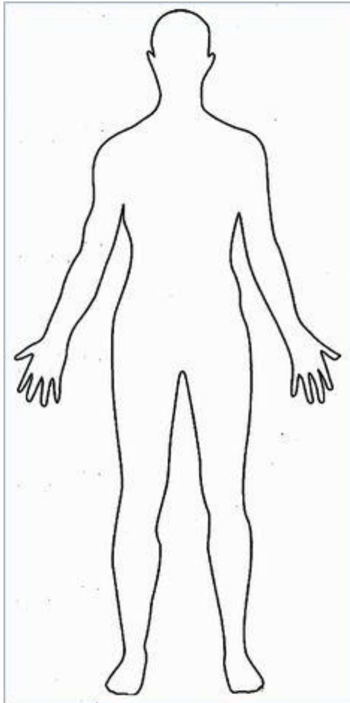
Name: ____

Referring Provider: ______________________________________

About your current rash

Please indicate where you have rash:

When did it first start? ______________



Do you have a history of the following:

Eczema or sensitive skin?	Y	N
Asthma?	Y	N
Seasonal allergies?	Y	N

Does anyone in your family have:

Eczema?	Y	N
Asthma?	Y	N
Seasonal allergies?	Y	N

What do you think may be causing your rash?

____

____

Occupation:

____

Please list your hobbies:

____

Have you ever noticed sensitivity to metals (such as jewelry)? Y N

Exposures

Over the last year, how frequently do you come into contact with the following?

	Never	Rarely	Monthly	Weekly	Daily
Plants (house or garden), trees	☐	☐	☐	☐	☐
Engine greases	☐	☐	☐	☐	☐
Metal compounds	☐	☐	☐	☐	☐
Building/Construction materials	☐	☐	☐	☐	☐
Technical oils/cutting fluids	☐	☐	☐	☐	☐
Photographic chemicals	☐	☐	☐	☐	☐
Sawdust, woodworking materials	☐	☐	☐	☐	☐
Plastics, glues, adhesives	☐	☐	☐	☐	☐
Rubber materials	☐	☐	☐	☐	☐
Paints, lacquers, coatings	☐	☐	☐	☐	☐
Essential oils	☐	☐	☐	☐	☐

Other exposures you think might be relevant: ______________________________

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Personal Products

- *Please list all personal products that you use in one month (include brands and be as specific as possible so we can look up ingredients if needed).*
- *If you recently changed your products, please also include your old products.*
- *Feel free to attach more as you deem necessary.*

Soaps

Face (include toner and make-up remover): ________________________

Body: ________________________

Hand/dish soap: ________________________

Shampoo/conditioner: ________________________

Lotions

Face: ________________________

Body/Hand: ________________________

Other Toiletries

Toothpaste/mouthwash/gum: ________________________

Shaving cream/deodorant: ________________________

Laundry detergent/Softener/Bleach: ________________________

Wet wipes/hand sanitizers: ________________________

Perfume/cologne/essential oils: ________________________

Cleaners/Lysol/scented candles: ________________________

Makeup and Miscellaneous

Lip products (chapstick, lipstick): ________________________

Eye products (eye drops, contact solution, eyeliner): ________________________

Nail polish/acrylics/gel: ________________________

Hair dye/products: ________________________

Other: ________________________

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