



part of the medical practice of Clovis E. Manley, MD

### Rosacea History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Check the symptoms that you have and explain:**

- Flushing/blushing of the face \_\_\_\_\_
- Permanent redness of the face \_\_\_\_\_
- Facial burning \_\_\_\_\_
- Damaged blood vessels on the face (spiders) \_\_\_\_\_
- Facial papules (red bumps) \_\_\_\_\_
- Facial pustules (pimples) \_\_\_\_\_
- Swelling of the facial skin \_\_\_\_\_
- Enlarged nose (rhinophyma) \_\_\_\_\_
- Eye involvement \_\_\_\_\_
- Other \_\_\_\_\_

**What triggers your facial flushes?**

- |   |                                      |                                     |                                      |
|---|--------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Warm environment     | <input type="checkbox"/> Hot foods   | <input type="checkbox"/> Hot drinks | <input type="checkbox"/> Spicy foods |
| <input type="checkbox"/> Embarrassment        | <input type="checkbox"/> Anger       | <input type="checkbox"/> Stress     | <input type="checkbox"/> Exercise    |
| <input type="checkbox"/> Mental concentration | <input type="checkbox"/> Crying      | <input type="checkbox"/> Chewing    | <input type="checkbox"/> Smiling     |
| <input type="checkbox"/> Skincare products    | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Heat       | <input type="checkbox"/> Sun         |
| <input type="checkbox"/> No reason at all     | <input type="checkbox"/> Wind        | <input type="checkbox"/> Alcohol    | <input type="checkbox"/> Other _____ |

**What types of oral antibiotics are you using or have you tried and how long?**

- |   |   |
|---|---|
| <input type="checkbox"/> Tetracycline _____           | <input type="checkbox"/> Doxycycline _____  |
| <input type="checkbox"/> Minocycline _____            | <input type="checkbox"/> Erythromycin _____ |
| <input type="checkbox"/> Metronidazole _____          | <input type="checkbox"/> None               |
| <input type="checkbox"/> Other (please explain) _____ |   |

**What types of topical agents are you using or have you tried and for how long?**

- |  |  |
|--|--|
| <input type="checkbox"/> Topical metronidazole _____ | <input type="checkbox"/> Topical azelaic acid _____                  |
| <input type="checkbox"/> Isotretinoin _____          | <input type="checkbox"/> Sodium Sulfacetamide (10%)/Sulfur(5%) _____ |
| <input type="checkbox"/> None _____                  | <input type="checkbox"/> Other (please explain) _____                |

**Have you previously seen a dermatologist or another physician in the past for this condition? Please list:**

\_\_\_\_\_