Hidradenitis Suppurativa (HS) Electronic Medical Record Template Questionnaire for New Patients

Patient HS History Questionnaire

HS Symptom Screening

- Have you had 2 or more boils, nodules (lumps under the skin), abscesses or tunneling skin lesions within a 6-month period?
  - ❑ Yes ❑ No
- **Where do you get these skin lesions?**
  - ❑ Armpits ❑ Underneath the Breasts
  - ❑ Groin ❑ Buttocks
  - ❑ Abdomen ❑ Pubic/genital areas
  - ❑ Other (please specify): _________
- **How long (approximately) have you had these skin lesions?** ________________ (months/years)
- **HS symptoms (check all that apply)**
  - ❑ Pain ❑ Itch
  - ❑ Wound drainage ❑ Odour
- **Have you previously received treatment for HS?** ❑ Yes ❑ No
- **Have you had any of the following treatments for HS?**
  - ❑ Topical antibiotics
  - ❑ Oral antibiotics
  - ○ Duration of oral antibiotic treatment: ______________
  - ○ Type of antibiotic:
    - ❑ Doxycycline ❑ Minocycline
    - ❑ Clindamycin ❑ Rifampin
    - ❑ Other (specify): _______________
  - ❑ Spironolactone
  - ❑ Corticosteroid injections
  - ❑ Laser Hair Removal
  - ❑ Incision and Drainage
  - ❑ Local surgical removal of a lesion
  - ❑ Biologic medications (e.g. Humira®)
  - ❑ Other prescription treatment (please specify):_________________
- **Do any of the following factors trigger HS flares? (check all that apply):**
  - ❑ Shaving/Waxing hair ❑ Excessive sweating
  - ❑ Diet ❑ Exercise/skin-to-skin friction
  - ❑ Menstrual cycle hormonal changes

Past Medical History

- **List all chronic health conditions that you've been diagnosed with:**
- **Current medications (list all):**
- **Have you ever been diagnosed with any of the following medical conditions (check all that apply)?**
  - ❑ Inflammatory bowel disease (including Crohn's disease and ulcerative colitis) Please specify if applicable ___________
  - ❑ Rheumatoid arthritis, psoriatic arthritis, or other type of arthritis? Please specify if applicable ___________
  - ❑ Polycystic Ovarian Syndrome
  - ❑ Pilonidal Sinus
  - ❑ Diabetes (Type 1 or Type 2)
- **Are you currently or have you recently taken:**
  - **Lithium**
    - ❑ Yes ❑ No
  - **Birth Control (Including oral contraceptive pills, IUDs, contraceptive implants, hormonal patches/rings)**
    - ❑ Yes ❑ No ❑ Not applicable
    - Specify type/brand: ___________________
- **Are you planning to become pregnant in the next 1-2 years?**
  - ❑ Yes ❑ No ❑ Not applicable
- **Do you smoke (tobacco products)?**
  - ❑ Yes ❑ No
  - ❑ Previously smoked but quit Time since quitting smoking: __________
- **Approximate total number of years of smoking (if applicable)?** ___________
- **Average number of cigarettes per day?** _________