Name_____ Signature _____ Date _____

XTRAC Laser for Psoriasis: Consultation

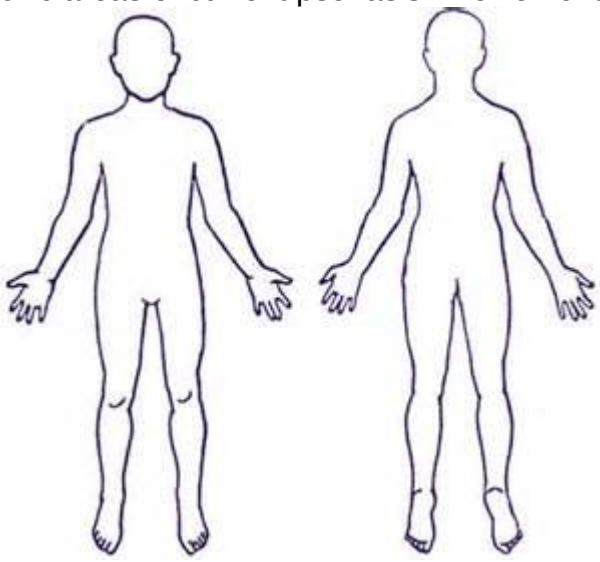
How long have you had psoriasis? _____

Do you have any joint pain due to psoriasis? If so, where? _____

Please circle any treatments tried in the past. Place a check mark next to any of the treatments which worked satisfactorily for you:

Over-the-counter shampoos: specific names _____
Topical steroids: specific names _____
Coal tar
Dovonex / Taclonex
Steroid injections
Light therapy / phototherapy
Methotrexate
Otezla
Cyclosporine
Humira / Enbrel / Stelara / Remicade / Other Biologic
XTRAC laser therapy
Other: _____

Please shade in all the specific areas of current psoriasis involvement:



Staff notes only below this line: _____

Psoriasis:_____

_____

_____

_____

_____ _____
Staff signature Date