**Patient Registration Form- Yearly update 2026**

**( Please complete in its entirety to ensure proper billing and insurance payment)**

## Welcome to Portland Allergy & Asthma! 2026

**1. What to Bring:** Please bring your insurance cards, a photo ID, and your completed new patient paperwork.

**2. Medications:** Please bring all current medications, including over-the-counter items and supplements, or a complete list of what you take.

**3. Arrival & Time:** Please arrive 30 minutes before your scheduled appointment time. We recommend allowing up to 1.5 hours for your first visit so we can thoroughly care for you.

**4. Rescheduling & Cancellations:** We understand plans change! If you need to cancel or reschedule, please give us at least 48 hours' notice to help us keep your referral active and avoid a $50.00 - $100.00 late cancellation fee.

**5. Health & Wellness:** If you are experiencing symptoms of COVID-19 or any respiratory illness, please call the clinic and speak to a member of the nursing staff prior to coming in for your appointment.

**6. Payments:** Co-pays and cash payments are due at the time of service.

**7. Minors:** Patients under the age of 18 must be accompanied by a parent or legal guardian.

**8. Policy Notice:** To help us stay on schedule and provide the best care, following these guidelines ensures your appointment goes smoothly.

**9. Cost Estimates:** If you would like an estimated cost for services prior to your visit, please let us know when scheduling appointments or call our Billing Department at 971-358-5600 option 2. Our billing team takes about 1 to 2 weeks to prepare estimated costs.

**Clackamas Clinic: 8740 SE Sunnybrook Blvd # 300, Clackamas 97015 PH 971-358-5600**
**Tigard Clinic: 9370 SW Greenburg Rd # 311, Portland 97223 PH 503-245-8060**
**Fax Number for all locations: 971-358-5801**

**All fields need to be filled out even if we have a copy of your insurance card:**

**Patient Registration Form- Yearly update 2026**

**( Please complete in its entirety to ensure proper billing and insurance payment)**

***Legal Name: _____Preferred Name:_____**

***Legal Sex: M or F( circle one) DOB:_____Pronouns:_____**

**Address:_____**

**Occupation:_____ Social Security number : _____**

**Phone #_____Email:_____**

**(signature on this form gives us permission to text or email based on clinic needs, and not used for marketing purposes)**

**Responsible Party if under 18: _____**

**Responsible Party Employer: _____ Phone#_____**

**DOB: _____Relationship_____**

**(Please provide even if you are giving us your insurance card - card is required)**

**Primary Insurance:_____**

**ID#_____Grp:#_____**

**Policy Holder's Name: _____ DOB:_____**

## Secondary Insurance (if applicable)

**Insurance:_____**

**ID#_____Grp#_____**

**Policy Holder Name: _____ DOB:_____**

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**( Please complete in its entirety to ensure proper billing and insurance payment)**

**Preferred Pharmacy:**_____**Location/Ph#**_____

**Emergency Contact:** _____**Ph#** _____

**Referring Provider/PCP:** _____

## Information Sharing Authorization

We respect your privacy. Please list anyone (family, friends, etc.) you permit us to share medical or billing details with. Note: You do not need to list doctors here.

**I (Signature):** _____ authorize Portland Allergy & Asthma to share and release my medical and billing information to the individuals named below. I understand I may cancel this authorization in writing at any time. (If no names are listed, we will only discuss information directly with you.)

**Name:**_____ **Ph#**_____ **Relationship:** _____

**Name:**_____ **Ph#**_____ **Relationship:** _____

**Or, I decline permission to discuss my medical/financial information with others outside of insurance companies or medical providers.**_____**(Initial)**

You are welcome to request a full copy of our Notice of Privacy Practices (HIPAA) at any time.

## Clinic and Financial Policies:

**1. Copays:** Copays are due at each visit. A $20.00 billing charge may apply if copays are not paid at the time of service. _____ (initial)

**2. Missed Appointments:** To ensure we can see all patients in need, we request more than 24 hours' notice for cancellations. A $50.00 fee applies to late-canceled office visits, and a $100.00 fee applies to late-canceled procedures. _____ (initial)

**Patient Registration Form- Yearly update 2026**

**( Please complete in its entirety to ensure proper billing and insurance payment)**

**3. Insurance & Coverage Verification**

**Prior to your visit, please contact your insurance company to review your benefits and check if you need a referral. Be sure to confirm:**

- **If Portland Allergy and Asthma is an in-network provider.**
- **Your coverage for specific services (e.g., office visits, testing, serums, injections, and other treatments).**
- **Whether a referral is required to be seen at our office.**
- **How your policy applies benefits to deductibles, copayments, and coinsurance._____ (initial)**

**Requesting a Cost Estimate: To request a cost estimate before your visit, you must contact our Billing Department directly prior to your appointment day:**

- **Phone: 971-358-5600 (Option 2)**
- **Timing: Requests must be made in advance. Cost estimates cannot be generated on the day of your scheduled appointment.**
- **Note: Initialing this document confirms acknowledgment only and does not submit an official request for an estimate._____ (initial)**

**4. Account Status:** Please ensure your account remains current so there are no interruptions to scheduling, prescription refills, or shots. _____ (initial)

**5. Payment Support:** We are always happy to work with you on payment arrangements. If an account remains overdue past 120 days without an arrangement, it may be placed with a collection agency. _____ (initial)

**6. Returned Payments:** A $50.00 fee applies to returned checks or payments. Future payments would then need to be made via card or cash. _____ (initial)

**7. Oral Immunotherapy (OIT):** There is a non-refundable $25.00 supply fee per visit for take-home doses. This covers customized preparation, foods, and specialized supplies.

***Supply charges are not covered by insurance and must be paid on or before your appointment.**

## ***High Deductible Plans***

We know medical expenses can be challenging, and our team is always here to assist you with payment options! For high deductible plans (remaining deductible over $1,000.00), a deposit of 20% of services or 20% of your remaining deductible (whichever is lower) is requested before care.

**Patient Registration Form- Yearly update 2026**

**( Please complete in its entirety to ensure proper billing and insurance payment)**

**Existing Balances & Future Appointments:** Payment plans apply exclusively to your balance at the time of setup. Future appointments are not added automatically and require separate payment alongside your scheduled monthly installments.

**Adding New Balances:** Should a subsequent visit exceed $300.00, contact the Billing Department to discuss incorporating it into your current agreement. Consolidating new balances into an active payment plan will increase your required monthly payment amount. The account guarantor remains responsible for coordinating financial arrangements directly with the Billing Department.

**Setting Up a Payment Plan:** To establish payment arrangements, please call our Billing Department at 971-358-5800 (Option 2).

**Online payments can be made at https://www.portland-allergy.com/**
**Click on the Blue Pay Now Button.**

## Agreement/Authorization

**By signing below, I acknowledge that I have read, understood, and agreed to the policies outlined above. I grant Portland Allergy and Asthma authorization to contact and bill my insurance carrier on my behalf, which includes releasing any required medical records. Additionally, I direct that payment of medical benefits be made directly to Portland Allergy and Asthma for any claims submitted on my behalf.**

**Patient/Responsible Party Signature:** _____

**Date signed:** _____

- **I understand** I can revoke this authorization at any time by written notice of my decision to:
- Portland Allergy and Asthma, ATTN: Vincent. 8740 SE Sunnybrook Blvd Suite 300 Clackamas, Or 97015.

- Revoking this authorization prevents Portland Allergy and Asthma from disclosing your information moving forward, but it does not apply to disclosures made prior to your request. Please note that if you revoke authorization for your insurance company, you will assume full responsibility for 100% of your bill, as we are unable to submit claims without active authorization.

# Portland Allergy & Asthma

## Health History Questionnaire

Patient Name: _____ Age: _____ Date of Birth: _____ Sex: M__F__

Primary Care Provider: _____

Preferred Pharmacy/Address: _____

Pharmacy Phone #: _____ Fax #: _____

**PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY.** Base your answers on your own observations and not on what others have told you or what you may have assumed on the basis of previous allergy tests. Please complete this form before seeing the allergist as the information will organize your thinking and help us to understand your problem.

**What are the problems that bring you to an allergist?**

_____

_____

**Please indicate the symptoms you experience:**

| EARS | Yes | No |
|---|---|---|
| Itching | ( ) | ( ) |
| Fullness | ( ) | ( ) |
| Popping | ( ) | ( ) |
| Tubes placed | ( ) | ( ) |
| Hard of hearing | ( ) | ( ) |
| Frequent infections | ( ) | ( ) |
| # ear infections/year _____ | | |

| NOSE/SINUS | Yes | No |
|---|---|---|
| Repeated Sneezing | ( ) | ( ) |
| Watery discharge | ( ) | ( ) |
| Stuffy nose | ( ) | ( ) |
| Itching | ( ) | ( ) |
| Nasal trauma | ( ) | ( ) |
| Bloody nose | ( ) | ( ) |
| Poor sense of smell | ( ) | ( ) |
| Mouth breathing | ( ) | ( ) |
| Bad breath | ( ) | ( ) |
| Snoring | ( ) | ( ) |

| THROAT | Yes | No |
|---|---|---|
| Soreness | ( ) | ( ) |
| Post-Nasal Drip | ( ) | ( ) |
| Itching of Palate | ( ) | ( ) |
| Recurrent Strep infections | ( ) | ( ) |
| Hoarseness | ( ) | ( ) |
| Tonsils | ( ) | ( ) |
| Adenoids removed | ( ) | ( ) |

| EYES | Yes | No |
|---|---|---|
| Contact Lenses | ( ) | ( ) |
| Itching | ( ) | ( ) |
| Burning | ( ) | ( ) |
| Watering | ( ) | ( ) |
| Swelling | ( ) | ( ) |
| Redness | ( ) | ( ) |
| Discharge | ( ) | ( ) |
| Glaucoma | ( ) | ( ) |
| Cataract | ( ) | ( ) |

How many times a year are you treated with antibiotics for nasal/sinus infections? _____

For how long each time? _____

Date of last sinus x-rays? _____ Date of last CT scan of sinuses? _____

Date of any sinus surgery _____

| CHEST | Yes | No |
|---|---|---|
| Cough | ( ) | ( ) |
| Wheezing | ( ) | ( ) |
| Sputum (phlegm) | ( ) | ( ) |
| Shortness of breath | ( ) | ( ) |
| at rest | ( ) | ( ) |
| with exercising | ( ) | ( ) |
| Coughed up blood | ( ) | ( ) |
| History of bronchitis | ( ) | ( ) |
| History of pneumonia | ( ) | ( ) |
| Positive TB skin test | ( ) | ( ) |

Date of last chest x-ray: _____

Result: _____

| SKIN | Yes | No |
|---|---|---|
| Eczema | ( ) | ( ) |
| Hives | ( ) | ( ) |
| Swelling | ( ) | ( ) |
| Infections (boils, impetigo) | ( ) | ( ) |

Names(s) of skin soap(s)/shampoo(s)/moisturizers used? _____

_____

_____

Do you have problems wearing LATEX GLOVES

Date of last pulmonary function studies: _____
Result: _____

or using latex products? (specify) _____

## ASTHMA HISTORY

Have you ever been intubated, placed in intensive care, or on a respirator for asthma? _____
# of hospitalizations for asthma: _____ # of emergency room visits for asthma in the last year: _____
Number of courses of oral steroids (Prednisone/Medrol) taken for asthma in the past year: _____
Do you have a peak flow monitor? _____ What is your best peak flow reading: _____
# of times per month awakened with asthma (chest tight/wheeze/cough/short of breath) _____
# of times per week you need to use inhaler for acute asthma (beyond scheduled doses) _____
Is your asthma worse at school or work? _____

## SEASONAL INCIDENCE

Please indicate your age when symptoms first appeared and check off the months in which the symptoms occur.

| | *Age of onset:* | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Wheezing | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Coughing | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Nasal | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Eye | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Hives | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Eczema | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Other | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |

Are symptoms worse after exposure to:

( ) Raking leaves
( ) Lawn mowing
( ) Hay/compost
( ) Damp basement
( ) Animals/Pets
( ) Humidity/heat
( ) Cold air
( ) Air conditioning
( ) Weather changes
( ) Smog (exhaust fumes)
( ) Cigarette smoke
( ) Perfumes
( ) Strong odors
( ) Newsprint
( ) Foods
( ) Medications

## ENVIRONMENT

How long have you lived in the Pacific Northwest? _____
Prior states(s)? _____
Type of home _____ How old is home? _____ How long lived there? _____
Location of home ( ) Country ( ) Suburb ( ) City
Basement ( ) yes ( ) no What is the basement used for? _____
Is basement ( ) dry ( ) damp
Does anyone at home smoke? ( ) yes ( ) no
Who? _____ How much? _____

## ANIMALS:

Do you have any pets? ( ) yes ( ) no
If yes, please list: _____
How long have the pets been with you? _____
Does the animal have full use of the house? ( ) yes ( ) no
Does the animal sleep on the patient's bed? ( ) yes ( ) no
Does animal exposure make symptoms worse? ( ) yes ( ) no

## PATIENT'S BEDROOM:

Mattress
Age: _____ years
Type:
Innerspring cotton ( )
Foam ( )
Other _____

Pillow(s)
Age: _____ years
Type:
Feather ( )
Foam rubber ( )
Synthetic ( )
Buckwheat ( )

## INSECT ALLERGY

After a bee sting do you have problems with:

Yes No Yes No

| | | | | | |
|---|---|---|---|---|---|
| Local swelling | ( ) | ( ) | Hives | ( ) | ( ) |
| Tongue/Lip swelling | ( ) | ( ) | Swelling | ( ) | ( ) |
| Scattered hives | ( ) | ( ) | Shortness of breath | ( ) | ( ) |

Have you ever been treated in an Emergency Room for an insect sting? _____ Date: _____

**FOOD ALLERGIES/SENSITIVITIES:** Do you have problems with any foods? If yes, describe problem. For instance: swelling or itching of tongue, lips, or mouth? Rashes or hives? Immediate or delayed vomiting or diarrhea?

Eggs _____
Wheat _____
Milk _____
Cheese _____
Shellfish _____
Tomatoes _____
Others _____

Fish _____
Melon _____
Bananas _____
Walnuts _____
Peanuts _____
Soy _____

**DRUG ALLERGIES/SENSITIVITIES:** Please list all medications to which you have had an adverse reaction and describe that reaction.

| Medication Name | Approximate date and description of reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

**PATIENT HEALTH HISTORY:** Have you had any of the following?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| High blood pressure | ( ) | ( ) | Diabetes | ( ) | ( ) |
| Heart disease or arrhythmia | ( ) | ( ) | Thyroid disease | ( ) | ( ) |
| Blood transfusion | ( ) | ( ) | Liver disease | ( ) | ( ) |
| Uncontrolled bleeding | ( ) | ( ) | Kidney disease | ( ) | ( ) |
| Dental problems | ( ) | ( ) | Arthritis | ( ) | ( ) |
| Cancer | ( ) | ( ) | Heartburn | ( ) | ( ) |
| Childhood Chicken Pox | ( ) | ( ) | Chronic diarrhea | ( ) | ( ) |

Other ongoing medical problems? Please list: _____

Surgeries: Please list procedure: Date:

Hospitalizations: Please list reason: Date:

**MEDICATIONS:** Please list **ALL** medications that you are currently taking, dosage, frequency, and for what condition(s).

| *Medication name/dosage* | *Frequency* | *For what condition(s)* |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## IMMUNIZATIONS:

| | Yes | No | Date(s) |
|---|---|---|---|
| Childhood series | ( ) | ( ) | |
| Hepatitis B | ( ) | ( ) | |
| Tetanus | ( ) | ( ) | |
| Pneumovax | ( ) | ( ) | |
| Chicken Pox Vaccine | ( ) | ( ) | |

## FAMILY HEALTH HISTORY

| | Mother | Father | Brother(s) | Sister(s) | Children | Grandparent(s) |
|---|---|---|---|---|---|---|
| Hay Fever/Allergies: | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Sinus Trouble: | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Asthma: | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Frequent Bronchitis: | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Eczema: | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Hives: | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Migraine Headaches: | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Thyroid Disease: | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Food Allergies: | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |
| Other: _____ | ( ) | ( ) | ( ) | ( ) | ( ) | ( ) |

Any other chronic illnesses, (i.e., heart, lung, kidney) or diseases? _____

## SOCIAL HISTORY

( ) Married ( ) Single ( ) Divorced ( ) Widowed

Occupation of patient: _____

Briefly describe workplace/school environment:

_____

Number of days work/school missed in last year: _____

Does the patient consume alcoholic beverages? ( ) yes ( ) no

If yes, type and frequency? _____

Does the patient smoke? ( ) Current ( ) Former ( ) Never

If yes, how many packs/day? _____

Please list your hobbies and/or spare time activities:

***THIS SECTION TO BE COMPLETED BY PHYSICIAN***

R.O.S. _____

_____

Eyes _____ Lungs _____

Ears _____ Heart _____

Nose _____ Abdomen _____

Sinus _____ Extremities _____

Oropharynx _____ Skin _____

Neck _____

Enter Name

Enter Address

Enter City/State/Zip

Today's Date: _____

Patient's Name: _____

FOR PATIENTS:

# Take the Asthma Control Test™ (ACT) for people 12 yrs and older.

## Know your score. Share your results with your doctor.

Step 1 Write the number of each answer in the score box provided.

Step 2 Add the score boxes for your total.

Step 3 Take the test to the doctor to talk about your score.

| | | | | | | | | | SCORE |
|---|---|---|---|---|---|---|---|---|---|
| 1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home? | All of the time | 1 | Most of the time | 2 | Some of the time | 3 | A little of the time | 4 | None of the time 5 | |
| 2. During the past **4 weeks**, how often have you had shortness of breath? | More than once a day | 1 | Once a day | 2 | 3 to 6 times a week | 3 | Once or twice a week | 4 | Not at all 5 | |
| 3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning? | 4 or more nights a week | 1 | 2 or 3 nights a week | 2 | Once a week | 3 | Once or twice | 4 | Not at all 5 | |
| 4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)? | 3 or more times per day | 1 | 1 or 2 times per day | 2 | 2 or 3 times per week | 3 | Once a week or less | 4 | Not at all 5 | |
| 5. How would you rate your **asthma** control during the **past 4 weeks**? | Not controlled at all | 1 | Poorly controlled | 2 | Somewhat controlled | 3 | Well controlled | 4 | Completely controlled 5 | |
| | | | | | | | | | TOTAL | |

Copyright 2002, by QualityMetric Incorporated.
Asthma Control Test is a trademark of QualityMetric Incorporated.

**If your score is 19 or less, your asthma may not be controlled as well as it could be. Talk to your doctor.**

FOR PHYSICIANS:

### The ACT is:

- A simple, 5-question tool that is self-administered by the patient
- Clinically validated by specialist assessment and spirometry[1]
- Recognized by the National Institutes of Health

Reference: 1. Nathan RA et al. *J Allergy Clin Immunol.* 2004;113:59-65.

# RHINITIS CONTROL ASSESSMENT TEST (RCAT)

**PATIENT NAME:** _____

**DATE COMPLETED:** _____

**PLEASE CHECK THE CATEGORY THAT BEST ANSWERS THE QUESTION.**
Write the score for each item in the column to the right.

**1. During the past WEEK, how often did you have nasal congestion?**

| Never | Rarely | Sometimes | Often | Extremely Often | SCORE |
|---|---|---|---|---|---|
| 5 ☐ | 4 ☐ | 3 ☐ | 2 ☐ | 1 ☐ | |

**2. During the past WEEK, how often did you sneeze?**

| Never | Rarely | Sometimes | Often | Extremely Often |
|---|---|---|---|---|
| 5 ☐ | 4 ☐ | 3 ☐ | 2 ☐ | 1 ☐ |

**3. During the past WEEK, how often did you have watery eyes?**

| Never | Rarely | Sometimes | Often | Extremely Often |
|---|---|---|---|---|
| 5 ☐ | 4 ☐ | 3 ☐ | 2 ☐ | 1 ☐ |

**4. During the past WEEK, to what extent did your nasal or other allergy symptoms interfere with your sleep?**

| Never | Rarely | Sometimes | Often | Extremely Often |
|---|---|---|---|---|
| 5 ☐ | 4 ☐ | 3 ☐ | 2 ☐ | 1 ☐ |

**5. During the past WEEK, how often did you AVOID any activity (for example, gardening, exercising, visiting a house with a dog or cat) because of your nasal or other allergy symptoms?**

| Never | Rarely | Sometimes | Often | Extremely Often |
|---|---|---|---|---|
| 5 ☐ | 4 ☐ | 3 ☐ | 2 ☐ | 1 ☐ |

**TOTAL SCORE**

The higher the score, the better controlled you are with your nose and eye symptoms.

A score that is **lower** than **21** suggest that you are not well-controlled.

# WEEKLY URTICARIA ACTIVITY SCORE (UAS7)

Please complete the diary for 7 days. This will provide your UAS7 score for the week before your next appointment.

When completing the diary, please try to reflect the previous 24 hours as a whole, not merely the current situation.

## Step 1: Instructions

Evaluate the **last 24 hours** in terms of both the wheals (hives) and the itching with a score, using the scale described in the table below:

| Wheals (hives) Score | Itching Score |
|---|---|
| 0 = No wheals | 0 = None |
| 1 = Mild (<20 wheals) | 1 = Mild (present but not annoying or troublesome) |
| 2 = Moderate (20–50 wheals) | 2 = Moderate (troublesome but does not interfere with normal daily activity or sleep) |
| 3 = Intense (>50 wheals) | 3 = Intense (severe itch, which is sufficiently troublesome to interfere with normal daily activity or sleep) |

For instance, if you had 30 wheals in the past 24 hours, you would score a **2** for wheals. If your itching in the past 24 hours was intense and interfering with sleep, you would score a **3** for itch, making your total score for the day: 2 + 3 = **5**.

| | Wheals Score/24h | | | | Itching Score/24h | | | | Total |
|---|---|---|---|---|---|---|---|---|---|
| e.g. | 0 | 1 | ② | 3 | 0 | 1 | 2 | ③ | 5 |

## Step 2: Your weekly UAS (UAS7)

Please enter your scores for the corresponding day in the table below by circling the appropriate number. Add the two scores together and write the total for that day in the right hand column.

Finally, at the end of the week, add the seven daily scores and enter your UAS7 score in the grey box.

| | | Wheals Score/24h | | | | Itching Score/24h | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Day | Date | None | Mild | Moderate | Intense | None | Mild | Moderate | Intense | Total |
| 1 | | 0 | 1 | 2 | 3 | 0 | 1 | 2 | 3 | |
| 2 | | 0 | 1 | 2 | 3 | 0 | 1 | 2 | 3 | |
| 3 | | 0 | 1 | 2 | 3 | 0 | 1 | 2 | 3 | |
| 4 | | 0 | 1 | 2 | 3 | 0 | 1 | 2 | 3 | |
| 5 | | 0 | 1 | 2 | 3 | 0 | 1 | 2 | 3 | |
| 6 | | 0 | 1 | 2 | 3 | 0 | 1 | 2 | 3 | |
| 7 | | 0 | 1 | 2 | 3 | 0 | 1 | 2 | 3 | |
| | | | | | | | | Weekly Total (UAS7) | | |

**Thank you. Please remember to bring this completed form to your next appointment.**

Novartis Pharmaceuticals has sponsored the production of this form.

# POEM

Patient-Oriented Eczema Measure

University of Nottingham
UK | CHINA | MALAYSI

## POEM for self-completion and/or proxy completion

Patient Details: _____

_____

_____

_____

Date: _____

Please circle one response for each of the seven questions below about your/your child's eczema. If your child i old enough to understand the questions then please fill in the questionnaire together. Please leave blank an questions you feel unable to answer.

**1. Over the last week, on how many days has your/your child's skin been itchy because of the eczema?**

No days | 1-2 days | 3-4 days | 5-6 days | Every day

**2. Over the last week, on how many nights has your/your child's sleep been disturbed because of the eczema?**

No days | 1-2 days | 3-4 days | 5-6 days | Every day

**3. Over the last week, on how many days has your/your child's skin been bleeding because of the eczema?**

No days | 1-2 days | 3-4 days | 5-6 days | Every day

**4. Over the last week, on how many days has your/your child's skin been weeping or oozing clear fluid because of the eczema?**

No days | 1-2 days | 3-4 days | 5-6 days | Every day

**5. Over the last week, on how many days has your/your child's skin been cracked because of the eczema?**

No days | 1-2 days | 3-4 days | 5-6 days | Every day

**6. Over the last week, on how many days has your /your child's skin been flaking off because of the eczema?**

No days | 1-2 days | 3-4 days | 5-6 days | Every day

**7. Over the last week, on how many days has your/your child's skin felt dry or rough because of the eczema?**

No days | 1-2 days | 3-4 days | 5-6 days | Every day

# POEM

Patient-Oriented Eczema Measure

University of Nottingham
UK | CHINA | MALAYSI

## POEM for self-completion and/or proxy completion

### How is the scoring done?

Each of the seven questions carries equal weight and is scored from 0 to 4 as follows:

| | |
|---|---|
| No days | = 0 |
| 1-2 days | = 1 |
| 3-4 days | = 2 |
| 5-6 days | = 3 |
| Every day | = 4 |

**Note:**

- If one question is left unanswered this is scored 0 and the scores are summed and expressed as usual out of a maximum of 28

- If two or more questions are left unanswered the questionnaire is not scored

- If two or more response options are selected, the response option with the highest score should be recorded

### What does a poem score mean?

To help patients and clinicians to understand their POEM scores, the following bandings have been established (see references below):

- 0 to 2 = Clear or almost clear
- 3 to 7 = Mild eczema
- 8 to 16 = Moderate eczema
- 17 to 24 = Severe eczema
- 25 to 28 = Very severe eczema

### Do I need permission to use the scale?

The POEM scale is protected by copyright. Commercial users must pay a per patient fee – details are available at https://licensing.micragateway.org/product/poem---patient-orientated-eczema-measure

POEM remains freely available for non-commercial use and can be downloaded from: www.nottingham.ac.uk/dermatology
We do however ask that you register your use of the POEM by e-mailing cebd@nottingham.ac.uk with details of how you would like to use the scale, and which countries the scale will be used in.

**References**

Charman CR, Venn AJ, Williams HC. The Patient-Oriented Eczema Measure: Development and Initial Validation of a New Tool for Measuring Atopic Eczema Severity From the Patients' Perspective.
Arch Dermatol. 2004;140:1513-1519

Charman CR, Venn AJ, Ravenscroft JC, Williams HC. Translating Patient-Oriented Eczema Measure (POEM) scores into clinical practice by