



ONLINE CONSULTATION

(NOTE: This process is available to patients anywhere in the world. Australian patients cannot use the online consultation process. Please contact us on **03 9770 5337** or send us an email TO BOOK AN APPOINTMENT.)

There is a consultation fee of AUD \$90.00 and we will require your credit card details in order to process your questionnaire.

Due to the time differences between your Country and our clinic in MELBOURNE, AUSTRALIA, **THERE MAY BE A TIME DELAY OF 24 - 48 HOURS** between the time you have submitted the information to us and Dr Tirant or our other Practitioner, Emma Stimpson, reply back to you. Debiting of your account will only occur on completion of assessment of your information and a consultation reply sent to you.

Should **YOU FAIL** to answer any of the questionnaires in full, truthfully or correctly, we cannot be held responsible for any information or guidelines that may be proposed.

This consultation can only be used to assist in the treatment of the specified complaint as stated by you. However, it would be of assistance to Dr Tirant / Emma Stimpson if you could also supply a copy of a referral from your current treating Practitioner or Specialist confirming the skin condition and areas of involvement.

Although you may wish to have your general practitioner or Specialist assist you in completing the details requested, it should be noted that Dr Tirant / Emma Stimpson has, at all times, professional control over any suggested Treatment protocols and guidelines.

Please attach your photographs in “JPEG” files and keep in within 1mb in size. It would be helpful if you could give both close up views and overall views of the areas covered by the condition.

Psoriasis & Skin Clinic

MELBOURNE : Suite 7 / 517 ST KILDA ROAD, Melbourne, 3004 (4th Floor)
FRANKSTON : 350 Nepean Highway, Frankston, 3199
TELEPHONE : (03) 9770 5337 **INTERNATIONAL:** +61 3 9770 5337
FACSIMILE : (03) 9770 5119 **INTERNATIONAL:** +61 3 9770 5119
WEBSITE : www.psoriasis.com.au **INTERNATIONAL:** www.psoriasisandskinclinic.com

ALL CORRESPONDENCE: P.O. Box 1430, Frankston, Victoria 3199, Australia



First Name:		
Surname:		
Email Address:		
Postal Address:		
Phone Number:		
Date of Birth:	Height:	Weight:
Blood Type:		

1) What is your current complaint you are requesting treatment for?

(e.g.) Psoriasis, Rosacea, Dermatitis, Eczema, Ichthyosis, Pityriasis, Acne, Heat Rash, Folliculitis, Fungal Infections, Tinea, etc.

2a) Have you been diagnosed by a medical practitioner/specialist?

Yes	No
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If yes, what treatment has been prescribed for you, if any? And INDICATE how useful it has been in treating your condition?

(Please tick the box if treatment has been used)		Very Useful	Some Usefulness	Not At All
<input type="checkbox"/>	Coal Tar Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Steroid Creams & Ointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Methotrexate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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<input type="checkbox"/>	Phototherapy (UV Rays)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Topical Retinoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Cyclosporine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Anthralin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Vitamin A Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Vitamin D Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Moisturisers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Natural Sunlight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Have not been treated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	Others: (please give details of name and usefulness)			

2b) If you answered 'Have not been treated', is the condition:

<input type="checkbox"/> Static	<input type="checkbox"/> Where currently presenting, getting worse
<input type="checkbox"/> Slowly spreading	<input type="checkbox"/> Rapidly spreading

3) What areas of your body are affected by the condition?

(Please select the part of the body affected and indicate the affected areas)					
<input type="checkbox"/>	Scalp	<input type="checkbox"/> All	<input type="checkbox"/> Nape	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Hairline	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Scattered		
<input type="checkbox"/>	Face	<input type="checkbox"/> All	<input type="checkbox"/> Cheeks	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Eyebrows	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Ears	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Chin		
			<input type="checkbox"/> Lips		
			<input type="checkbox"/> Nose		
<input type="checkbox"/>	Neck	<input type="checkbox"/> All	<input type="checkbox"/> Front	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Back	<input type="checkbox"/> L	<input type="checkbox"/> R

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<input type="checkbox"/>	Arms	<input type="checkbox"/> All	<input type="checkbox"/> Elbows	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Upper	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Lower	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/>	Hands	<input type="checkbox"/> All	<input type="checkbox"/> Palms	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Back	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Nails	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Arthritis	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Fingers	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/>	Chest	<input type="checkbox"/> All	<input type="checkbox"/> Upper	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Lower	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Side	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/>	Abdomen	<input type="checkbox"/> All	<input type="checkbox"/> Centre	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Side	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Lower	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/>	Back	<input type="checkbox"/> All	<input type="checkbox"/> Upper	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Lower	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Side	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Buttocks	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/>	Legs	<input type="checkbox"/> All	<input type="checkbox"/> Thigh	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Calf	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Knee - front	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Knee - back	<input type="checkbox"/> L	<input type="checkbox"/> R
<input type="checkbox"/>	Feet	<input type="checkbox"/> All	<input type="checkbox"/> Ankles	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Sole	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Upper	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Nails	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Arthritis	<input type="checkbox"/> L	<input type="checkbox"/> R
			<input type="checkbox"/> Toes	<input type="checkbox"/> L	<input type="checkbox"/> R

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<input type="checkbox"/>	Genitalia
<input type="checkbox"/>	Others, Please Specify

4) What 'Percentage' of your body, would you say is covered?

5) Are you aware of anything that irritates or makes your condition worse?

<input type="checkbox"/> Stress	<input type="checkbox"/> Sunlight
<input type="checkbox"/> Alcohol	Specify:
<input type="checkbox"/> Foods	Specify:
<input type="checkbox"/> Medications	Specify:
<input type="checkbox"/> Any other irritant - (e.g.) Chemicals, Dyes, Paints, Plants, Rubber, Gums, Glue, <input type="checkbox"/> Make-up, Eye shadows, Lipsticks, Heat/Cold, Dryness, Synthetic fibres, Animals, Smoking.	Please specify here:

6) **FAMILY HISTORY** – Cancer, Thyroid, Diabetes, Blood Pressure, Heart, Skin Conditions, etc.

7) **YOUR MEDICAL HISTORY** – Cancer, Thyroid, Diabetes, Blood Pressure, Heart, Allergies or other conditions.

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8) Do you smoke?

If yes, how many per day?

 Yes No

9) Do you have any of the following?

<input type="checkbox"/> Reflux	<input type="checkbox"/> Alopecia	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Hyper Thyroidism	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Dandruff
<input type="checkbox"/> Gout	<input type="checkbox"/> Digestive Problems	<input type="checkbox"/> Hayfever
<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Fungal Problems	<input type="checkbox"/> Nails Problems
<input type="checkbox"/> Nerves Stress	<input type="checkbox"/> Constipation	<input type="checkbox"/> Warts

10) Please Specify in Detail, including any medications not previously covered.

11) Do you have any other skin complaints? If yes, Please specify.

12) Do you work in an environment that exposes you to chemicals? Or, do you have a recreational activity, e.g.) swimming in a chlorinated pool, that exposes you to chemicals? If yes, Please specify.

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Question 13a & 13b are for Women Only:

13a) Are you menopausal?

Yes

No

13b) What are you symptoms?

DIET

14) Do you consume:-

		Per Day			Per Week			
		0	1-2	3+	0-2	3-5	6-8	9+
Green Vegetables:	Fresh	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Frozen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acidic Foods:	Tomatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chillies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Spices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Citrus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Berries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pineapple	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natural Diuretics:	Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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		Per Day			Per Week			
		0	1-2	3+	0-2	3-5	6-8	9+
Alcohol:	White Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Red Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Spirits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat:	Red	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Pork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Chicken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lamb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish:	Fresh	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Tinned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Foods:	Wheat/Gluten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Eggplant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Potatoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Onions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Garlic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dairy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Mushrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Shellfish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	MSG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Coconut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Peanuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Avocado	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lentils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Processed Meats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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15) Do you have any Allergies to Essential Oils or plants of any kind?

16) Do you have any other comments or queries?

What Now?

Once Dr Tirant / Emma have evaluated your medical history and the information supplied, in some instances, Practitioner may telephone you to discuss certain details or send an email requesting additional information.

After the practitioner has completed the assessment, an email reply will be sent to you, detailing the medications that you will require and the evaluation of your condition.

Upon subsequent placement of your order, we will send a detailed Treatment Protocol plan to you, together with your medications.

<u>Credit Card Details</u>	
Type of Card:	VISA / MASTERCARD / AMERICAN EXPRESS / OTHERS Please Specify:
Name on Card:	
Card Number:	
Expiry Date:	

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