Vamos

Restoring Origin of Cell Life

VAMOS HOLDINGS LIMITED
Unit 25A, 25F, Wing Hing Commercial Building
139 Wing Lok Street, Sheung Wan, Hong Kong
T : +603 2011 3783
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www.vamos-holdings.com

PSORIASIS VULGARIS
TREATMENT ASSESMENT FORM

YOUR PERSONAL INFORMATION

Vamos Representative	
Date	
Patient	
Surname	
Given Names	
Date of Birth	
Age	
Gender	
Nationality	
IC/Passport Number	
Address	
City	
Post Code	
Country	
Phone	
Mobile	
Email address	
Wechat ID	
Skype ID	
Occupation	
Religion	
Height (in cm)	
Weight (in kg)	
Marital Status:	
Number of Children	
Ages of Children	
Emergency Contact Person	
Name	
Address	
Phone	
Email	
Special Needs	
Wheelchair	
Carer-assisted	
Languages	

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HISTORY OF DISEASE

YEAR STARTED:

DESCRIOTION OF DISEASE:

OTHER COMPLAINTS

1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

CURRENT MEDICATIONS TAKEN

Name	Dosage	Usage

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SYMPTOMS

Do you have any of the symptoms described below?	Answer with YES or NO
1. Rashes or patches of red, inflamed skin, often covered with loose, silver-coloured scales? (Y/	
2. Itchy, painful skin that can crack or bleed	
3. Small areas of bleeding where the involved skin is scratched	
4. Problems with your fingernails and toenails, including discoloration and pitting? 5. If Yes did your nails begin to crumble or detach from the nail bed?	
6. Scaly plaques on the scalp	

VITAL SIGNS

Blood Pressure (H/L)	
Pulse	
Fasting Sugar Level	
Temperature	

MEDICAL HISTORY

Diabetes		Infectious Disease	
Heart Disease		Gynaecological problems	
Stroke		Urological problems	
Hypertension		Night sweats	
Respiratory disease		Frequent fever	
Thyroid disease		Unwanted weight loss	
Cancer		Skin disease	
Unwanted Weight Gain		Teeth root canal filling	
Vaccination within last 4 weeks		Teeth fillings material	

PREVIOUS SURGICAL OPERATIONS

1	
2	
3	

KNOWN ALLERGIES

Drug Allergies, please specify agent	
Food intolerance, please specify agent	
Others (Please Specify)	

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REGULAR EXERCISE

How many sessions per week	
How long is each session	
Easy fatigability (tiredness)	
Other comments	

NUTRITION

Vegetarian (yes/no)	
Balanced mixed diet (yes/no)	
Other non-medical drugs	

ALCOHOLIC BEVERAGE HISTORY

Occasional drinker (yes/no)	
non-alcoholic beverage drinker (yes/no)	
Type of alcoholic beverage	

SMOKING/COFFEE/DRUG HISTORY

Number of packs per day	
Number of years smoking	
When did you stop smoking?	
Number of coffee cups per day	
Number of years drinking coffee	
When did you stop drinking coffee	
Use of Recreational drug (yes/no)	
Type of drugs used	
Other non-medical drugs	

EMOTIONAL WELLBEING

Condition	**Please rate with a number from 1 to 10**
Anxiety	
Aggressiveness	
Depression	
Mood swings	
Sharpness	
Concentration	
Self-Confidence	
Stress	

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SLEEP

Average hours of sleep	
Quality of sleep	
Trouble falling asleep	
Waking up during the night	
Nervous/anxious/restless sleep	
Wake up rested	
Sleeping Medication	
Snoring	
Teeth grinding while sleeping	

In the previous 4 weeks, have you resided or travelled to any of the following countries in West Africa: Liberia, Sierra Leone, Guinea or any region where **Ebola Virus Disease (EVD)** outbreak transmission is active?