CASE N° :

Please answer the questions below carefully

Date: /__/__/ /__/__/ /__/__/
d d m m y y

YOUR PERSONAL INFORMATION

Surname: /__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/ First name: /__/__/__/__/__/__/__/__/__/__/__/__/__/__/__/

Sex: F /__/ M /__/ Date of birth: /__/__/ /__/__/ /__/__/
d d m m y y

Address: ____

Postcode: /__/__/__/__/__/__/__/ Town: ____________________ Country: ______________

Telephone: ____________________ E-mail:____________________________

N.B.: If you are filling in this form with the help of a friend or relative, please state his/her name and relationship to you:

____

PRODUCT SUSPECTED IN YOUR REACTION

Name of **product 1**: ______________________________ Brand: ______________

Batch number: ____________ Expiry date: /__/__/ /__/__/__/__/ Date of purchase: ____________
(appears on product and/or packaging, e.g.: F89, AV200 etc) *(approximately)*

Place of purchase: ____

Purpose for using product: ____

Name of **product 2**: ______________________________ Brand: ______________

Batch number: ____________ Expiry date: /__/__/ /__/__/__/__/ Date of purchase: ____________
(appears on product and/or packaging, e.g.: F89, AV200 etc) *(approximately)*

Place of purchase: ____

Purpose for using product: ____

Name of **product 3**: ______________________________ Brand: ______________

Batch number: ____________ Expiry date: /__/__/ /__/__/__/__/ Date of purchase: ____________
(appears on product and/or packaging, e.g.: F89, AV200 etc) *(approximately)*

Place of purchase: ____

Purpose for using product: ____

USE OF PRODUCT SUSPECTED IN YOUR REACTION

Had you used this product previously?

Product 1: yes /__/ no /__/ date: /__/__/ /__/__/ /__/__/
d d m m y y

If yes, did you experience a reaction to **product 1** when you previously used it? yes /__/ no /__/

Product 2: yes /__/ no /__/ date: /__/__/ /__/__/ /__/__/
d d m m y y

If yes, did you experience a reaction to **product 2** when you previously used it? yes /__/ no /__/

Product 3: yes /__/ no /__/ date: /__/__/ /__/__/ /__/__/
d d m m y y

If yes, did you experience a reaction to **product 3** when you previously used it? yes /__/ no /__/

Thinking only about the time from the beginning of use to when you experienced the reaction:

When did you start using **product 1**? /__/__/ /__/__/ /__/__/
d d m m y y

For how long did you use it? /__/__/ *day(s)* /__/__/*week(s)* /__/__/*month(s)* /__/__/*year(s)*

How often? /__/__/ *times/day* /__/__/ *times/week* /__/__/ *times/month* /__/__/ *times/year*

other: ____

Did you use it according to the instructions?

yes /__/ no /__/ describe the circumstances ________________________________

____

When did you start using **product 2**? /__/__/ /__/__/ /__/__/
d d m m y y

For how long did you use it? /__/__/ *day(s)* /__/__/*week(s)* /__/__/*month(s)* /__/__/*year(s)*

How often? /__/__/ *times/day* /__/__/ *times/week* /__/__/ *times/month* /__/__/ *times/year*

other: ____

Did you use it according to the instructions?

yes /__/ no /__/ describe the circumstances ________________________________

____

When did you start using **product 3**? /__/__/ /__/__/ /__/__/
d d m m y y

For how long did you use it? /__/__/ *day(s)* /__/__/*week(s)* /__/__/*month(s)* /__/__/*year(s)*

How often? /__/__/ *times/day* /__/__/ *times/week* /__/__/ *times/month* /__/__/ *times/year*

other: ____

Did you use it according to the instructions?

yes /__/ no /__/ describe the circumstances ________________________________

____

DESCRIPTION OF YOUR REACTION

Please state the date of onset of your reaction: /__/__/ /__/__/ /__/__/
d d m m y y

Did you experience the reaction the first ever time you used **product 1?**

yes /__/ how long exactly following application? ____________________

no /__/

If you answered "no", how much time passed between the last application of **product 1** and the reaction?

____

Where precisely did you apply **product 1**? ____________________

____

Did you experience the reaction the first ever time you used **product 2?**

yes /__/ how long exactly following application? ____________________

no /__/

If you answered "no", how much time passed between the last application of **product 2** and the reaction?

____

Where precisely did you apply **product 2**? ____________________

____

Did you experience the reaction the first ever time you used **product 3?**

yes /__/ how long exactly following application? ____________________

no /__/

If you answered "no", how much time passed between the last application of **product 3** and the reaction?

____

Where precisely did you apply **product 3**? ____________________

____

On which area did the reaction occur? ____________________

____

What did you notice and what effects did you feel? ____________________

____

____

____

____

Did you expose your skin to sunshine shortly after or during your reaction?

yes /__/ how near in time to the reaction? ____________________

no /__/

Did you take any photographs of your reaction? yes /__/ no /__/

N.B.: If you wish, you can attach photographs to this questionnaire, we will look at them and deal with them confidentially

YOUR OWN DERMATOLOGICAL HISTORY

Do you have a history of skin reactions?

yes /__/ what type(s)?____

do you have any allergies? yes /__/ no /__/

if yes, to what are you allergic?

____

what tests were used to identify these allergies?

____

no /__/

OUTCOME OF YOUR REACTION

Did you stop using the **product 1** because of your reaction?

yes /__/ When (date)? /__/__/ /__/__/ /__/__/
d d m m y y

no /__/

Did you stop using the **product 2** because of your reaction?

yes /__/ When (date)? /__/__/ /__/__/ /__/__/
d d m m y y

no /__/

Did you stop using the **product 3** because of your reaction?

yes /__/ When (date)? /__/__/ /__/__/ /__/__/
d d m m y y

no /__/

How did your reaction progress?

resolved /__/ improved /__/ ongoing /__/ got worse /__/

how long did this take? ____

Did you need to take any treatment for your reaction?

yes /__/ which? ____

for how long? ____

no /__/

MEDICAL CONSULTATION

Did you consult a healthcare professional for your reaction?

yes /__/ if yes, when (date)? /__/__/ /__/__/ /__/__/ no /__/
d d m m y y

If yes,
General Practitioner/__/ Dermatologist/__/ Allergologist/__/ Paediatrician/__/ Emergency/__/ Other/__/ : ________

Did the healthcare professional prescribe any treatment for your reaction?

yes /__/ which ? ____

for how long? ____

no /__/

Do you give consent for us to contact this healthcare professional and to send back us information about your reaction?

yes /__/ no /__/

If yes, please give his/her details below:

Name: ____

Address: ____

____

Telephone: ____

If appropriate, give details of any other healthcare professional you consulted about this:

Name: ____

Address: ____

____

Telephone: ____

RE EXPOSURE TO THE SUSPECTED PRODUCT

Have you used **product 1** again?

yes /__/ if yes, did the reaction occur again? yes /__/ no /__/

no /__/

did you use **product 1** in the same way and on the same area? yes /__/ no /__/

if no, give details: ____

Have you used **product 2** again?

yes /__/ if yes, did the reaction occur again? yes /__/ no /__/

no /__/

did you use **product 2** in the same way and on the same area? yes /__/ no /__/

if no, give details: ____

Have you used **product 3** again?

yes /__/ if yes, did the reaction occur again? yes /__/ no /__/

no /__/

did you use **product 3** in the same way and on the same area? yes /__/ no /__/

if no, give details: ____

OTHER PRODUCT(S) OR TREATMENT(S) YOU WERE USING WHEN THE REACTION OCCURRED (cosmetics, medications, food supplements, household products)

Brand name

______________________________ Start /__/__/ /__/__/ /__/__/ End /__/__/ /__/__/ /__/__/
d d m m y y d d m m y y

______________________________ Start /__/__/ /__/__/ /__/__/ End /__/__/ /__/__/ /__/__/
d d m m y y d d m m y y

______________________________ Start /__/__/ /__/__/ /__/__/ End /__/__/ /__/__/ /__/__/
d d m m y y d d m m y y

______________________________ Start /__/__/ /__/__/ /__/__/ End /__/__/ /__/__/ /__/__/
d d m m y y d d m m y y

______________________________ Start /__/__/ /__/__/ /__/__/ End /__/__/ /__/__/ /__/__/
d d m m y y d d m m y y

CARE HABITS

Which product(s) **from the same brand** as the product suspected in your reaction do you use regularly (for care of hair, face or body)?

____

____

____

Thank you very much for filling in this questionnaire, which should be returned to:

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23 Hyde Street,
Winchester, SO23 7DR
Tel: 00 44 (0)1962 874400 E-Mail: ukdrug_safety@pierre-fabre.com