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: _____

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: _____ 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?
yes /__/ no /__/ date: /__/__/ /__/__/ /__/__/
d d m m y y

If yes, did you experience a reaction to this product 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? /__/__/ /__/__/ /__/__/
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 this product**?**

yes /__/ how long exactly following application? _____

no /__/

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

_____

Where precisely did you apply this product**?**_____

_____

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 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 the product again?

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

no /__/

did you use the product 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 /__/__/ /__/__/ /__/__/ (d d m m y y) End /__/__/ /__/__/ /__/__/ (d d m m y y)

_____ Start /__/__/ /__/__/ /__/__/ (d d m m y y) End /__/__/ /__/__/ /__/__/ (d d m m y y)

_____ Start /__/__/ /__/__/ /__/__/ (d d m m y y) End /__/__/ /__/__/ /__/__/ (d d m m y y)

_____ Start /__/__/ /__/__/ /__/__/ (d d m m y y) End /__/__/ /__/__/ /__/__/ (d d m m y y)

_____ Start /__/__/ /__/__/ /__/__/ (d d m m y y) End /__/__/ /__/__/ /__/__/ (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: