



# Eczema Assessment

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

**Complete this form and take it to your physician at your next appointment. It helps your physician understand how eczema has affected you/your child in the past few months. Eczema often flares and then subsides. This form will help your physician understand what you experience.**

Circle the number that most closely matches your situation.

1. How often do you/your child have the rash/eczema?

Yearly	Every few months	Monthly	Weekly	Daily
1	2	3	4	5

2. How often do you/your child itch from eczema?

Never	Rarely	Sometimes	Often	All the time
0	1	2	3	4

3. How often does eczema interfere with sleep?

Never	Rarely	Sometimes	Often	All the time
0	1	2	3	4

4. How often does having eczema interfere with work, school, or recreational activities?

Never	Rarely	Sometimes	Often	All the time
0	1	2	3	4

5. How often does having eczema affect daily friendships, social life, or family/friend gatherings?

Never	Rarely	Sometimes	Often	All the time
0	1	2	3	4

6. How often does having eczema make you/your child sad, embarrassed, or upset?

Never	Rarely	Sometimes	Often	All the time
0	1	2	3	4

Score: Add score for each question above (to a maximum of 25).

**1-8 Mild    9-16 Moderate    17-25 Severe**

**Total Score**

**Body Surface Area**  
Shade the areas where you have recently experienced eczema.

Please provide any additional information or comments on the impact eczema has on your life.

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If additional space is needed, please write on back of page.



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