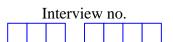
EUROPEAN REGISTRY OF SEVERE CUTANEOUS ADVERSE REACTIONS TO DRUGS AND COLLECTION OF BIOLOGICAL SAMPLES

RegiSCAR

1 Year-Questionnaire



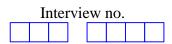
HSS/DRESS



This is a confidential document of high importance for health research. In case of loss, if someone finds it, please send it to the following address:

EUROPEAN REGISTRY OF SEVERE CUTANEOUS ADVERSEREACTIONS TO DRUGS AND COLLECTION OF BIOLOGICAL SAMPLES

R e g i S C A R 1 Year-Questionnaire



GENERAL DATA

1	Please fill in the								
(date of 1 year-follow-up								

Initials of the patient

dat	e o	f b	irth	l

One year ago when hospitalized for hypersensitivity syndrome (HSS/DRESS) also doctor

(name)

from our dermatological department came to visit you. You agreed to participate in a followup surveillance. Thank you for answering the following questions! We appreciate your help! Please do not hesitate to contact us for questions and help completing this questionnaire (our phone number:)!

1) Were you working before the severe cutaneous adverse reaction (SCAR), including school?

	no		yes	
yes, did you resume	your work (or sc	chool)?		
	no		yes	
If yes, when?				date
	partially			
	completely			
If no, why not?				

2) More generally, did you resume your daily activities?

		no	yes	
If yes,	partially			date
	completely			date

3) Have you been suffering from the following symptoms due to your hypersensitivity syndrome (HSS/DRESS)?

Skin: Hypocoloration of the skin	no	yes	no If yes, still present:	yes
Hypercoloration of the skin			If yes, still present:	
Pruritus			If yes, still present:	
Other skin or mucous membran	e problems?			
	no	yes		
If yes, please specify:			no Still present:	yes
If yes, please specify:			no Still present:	yes

To what extent does your skin problem affect your daily-life? Please circle one of the following:

not at all / slightly / moderately / quite a bit / extremely

 Iı	ntei	rvie	ew :	no.	

- 4 -

Organic health problems:

- At the 8 week-follow-up visit you had persisting signs/symptoms of: (to be completed by the investigator in advance)

still present		cured		date of cure	
still present		cured		date of cure	-
still present		cured		date of cure	_
still present		cured		date of cure	
Other health problems?	no	yes			
If yes, please specify:			 _ Still present:	no	yes
If yes, please specify:			_ Still present:	no	yes

To what extent does your organic health problem affect your daily-life? Please circle one of the following:

not at all	/ sl	ightly	/	moderately	/	quite a bi	it /	extremely
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Inter	vie	ew :	no.	

no	yes tain more details?
no	yes

4) Since the 8 week-follow-up visit did you have:

(Since the following questions are probably very difficult and detailed, we would like to ask your doctor directly. Please tell us the address of your doctor in case he or she is different from the above-mentioned one)

Name, address, phone:

		no	yes	unknown
- Blood count				
If yes:	normal	abnormal		
If abno	rmal, please spec	rify		

	- 6 -		Interview no.
	Year-Quest	ionnaire	
- Liver function test	no	yes	unknown
If yes: normal If abnormal, please sp	abnormal		
- Renal function test	no	yes	unknown
If yes: normal If abnormal, please sp	abnormal		
- Other blood test(s)	no	yes	unknown
If yes: normal If abnormal, please sp	abnormal		
If yes: normal	abnormal		
- X-ray, MRI, scanner	no	yes	unknown
If yes: normal If abnormal, please sp	abnormal		
- Other examination(s)	no	yes	unknown
If yes: normal If abnormal, please sp	abnormal		
If yes: normal If abnormal, please sp	abnormal		

5) Has any health professional suggested that your thyroid gland may function abnormally?



6) Did you notice the appearance or worsening of any of the following after your hypersensitivity syndrome (HSS/DRESS)?

- Aesthetic embaras	sement	no	yes				
If yes, to what extent does it affect your daily-life? Please circle one of the following							
not at all	/ slightly /	moderately /	quite a bit /	extremely			
- Impaired sleeping		no	yes				
If yes, to what extent does it affect your daily-life? Please circle one of the following							
not at all	/ slightly /	moderately /	quite a bit /	extremely			
- Bad dreams		no	yes				
	xtent does it affec		yes	of the following:			
If yes, to what e		t your daily-life?		-			
If yes, to what e	/ slightly /	t your daily-life?	Please circle one	-			
If yes, to what en not at all - Are you afraid of n	/ slightly / medications?	t your daily-life? moderately /	Please circle one quite a bit /	extremely			

Interview no.							

5) Some more questions:		
Were you hospitalized again	as a consequence	of your hypersensitivity syndrome (HSS/DRESS)?
	no	yes
If yes, total number of da	ays:	
After your hypersensitivity s	yndrome (HSS/D)	RESS) did you avoid using drugs?
	no	yes
If yes, please circle one of	or more of the follo	owing:
oral medication / topical medication / v (i.e., creams)	vaccination / i.vmedi	cation / dental injections / other:
After your hypersensitivity s	yndrome (HSS/D	RESS) did you avoid medical or dental care?
	no	yes
Did you get professional psyc (HSS/DRESS)?	hological suppor	t because of your hypersensitivity syndrome
	no	yes
If yes, please specify:		

Do you think professional psychological support would be helpful?

no		yes	

Interview no.							

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Do you consider t	hat your questio	ns about you	r disease ha	we been ad	lequately answered?		
	not at all	only partially	mo	stly	completely		
Has the cause of y	your disease been	detected?					
	no		yes				
If yes, please na	ame it as specific	as possible:					
Have you received written advice to avoid specific medication?							
114, 0 904 10001, 0	no		yes				
If yes, which or	ne?						

Thank you for answering our questions!

Please never hesitate to contact us whenever we can provide our help!

All the best for you!