Workers' Compensation Board
Alberta
Box 2415
Edmonton AB T5J 2S5
Fax 780-427-5863
1-800-661-1993

C437
DERMATITIS QUESTIONNAIRE

WCB Claim Number

Personal Health Number

Worker's *Surname* *First Name* *Initial*

Date of Birth *(Year / Month / Day)*

1. History

A. What do you think caused the condition?

B. Have you ever been exposed to harmful chemicals ie. hair colourants? ☐ Yes ☐ No If yes, (*specify)*

Exposure (home/work/both)	Chemical name	From (year)	To (year)	Skin contact	Other

2. Medical Information

A. Have you ever been told you have any of the following conditions?

	Yes	No	From (month/year)	To (month/year)	Attending Physician
Eczema	☐	☐			
Psoriasis	☐	☐			
Dermatitis	☐	☐			
Dyshidrotic Dermatitis	☐	☐			
Hives	☐	☐			
Asthma	☐	☐			
Hay Fever	☐	☐			
Diabetes	☐	☐			
Allergies *(specify)* _____	☐	☐			
Other skin conditions *(specify)*	☐	☐			

B. Medical Treatment

List any physicians you have seen for your current skin condition.

Physicians Name/Address and Telephone Number	Reason	Treatment Dates *(Year / Month / Day)*

Worker's *Surname*	*First Name*	*Initial*	WCB Claim Number

2. Medical Information - continued

C. Have you taken or are you currently taking medication for any skin, allergy or respiratory condition?

Name of Medication	Reason Prescribed

D. Have you or are you undergoing any treatment for this skin condition or any other related condition (i.e.home remedies, treatment that is not medically prescribed?) ☐ Yes ☐ No If yes, specify

E. Are you using protective clothing or creams at home or work? ☐ Yes ☐ No If yes, (*specify)*

3.

Family History: Have any family members suffered from any condition(s) listed in 2A (on first page) ☐ Yes ☐ No

If yes, please indicate below.

Relationship	**Skin Condition(s)**
Mother	
Father	
Brother/Sister	
Brother/Sister	
Brother/Sister	
Brother/Sister	
Brother/Sister	
Brother/Sister	

Comments

I, the claimant, declare the above information to be true and correct to the best of my knowledge

Date: Name (please print): Signature: