AANP American Association of Nurse Practitioners

Atopic Dermatitis Treatment Plan

Consistency is key to successfully maintaining healthy skin. Together, we can plan a routine to treat your atopic dermatitis (AD), or eczema, that's easy to follow and works with your lifestyle.

Name: _____ Date of Birth: _____ Today's Date: _____

Your next appointment is with: _____ on _____

How long have you had AD (or eczema)? _____

What symptoms or questions would you like to discuss today?

1.
2.
3.

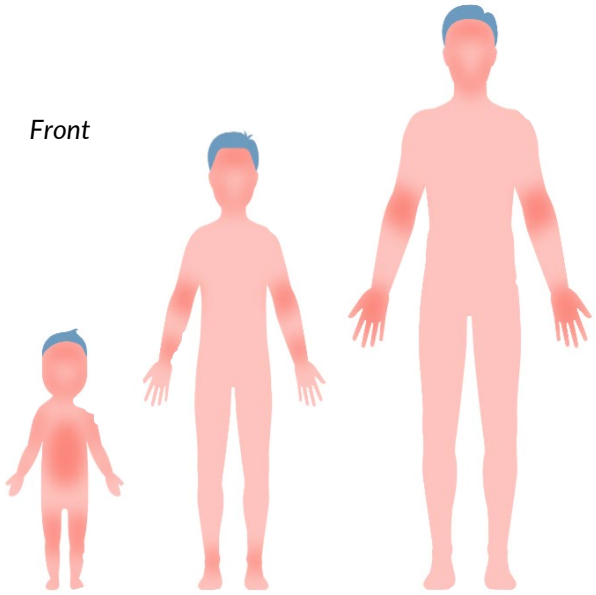
What symptoms do you have? (Check all that apply)	How often do these symptoms bother you?	What treatment(s), if any, have you tried?	How often do you treat this symptom?	Does this treatment make you feel: better (B), same (S), worse (W) or much worse (MW)?
☐ Dry skin				
☐ Red skin				
☐ Itchy skin, with or without rash				
☐ Scabbing that leaks or blisters when scratched				
☐ Cracked or peeling skin				
☐ Oozing, pus or warm, red skin				
☐ Sleep disturbance or daytime sleepiness				
☐ Asthma or breathing problems				
☐ Allergies (e.g., food, pet, environment, etc.)				
☐ Feelings of sadness or depression				
☐ Feelings of anxiousness or stress				
☐ Difficulty completing tasks or problems with concentration				
☐ Pain (e.g., lesions, joint pain, extremity pain, etc.)				
☐ Other (please explain)				

Continue other side

Where are your areas of concern today?

On the images below, please use an **X** to indicate where you are experiencing dry skin, itchiness or a rash, and use a **P** to indicate where you are experiencing pain.

Front



Right *Left*

_____

_____

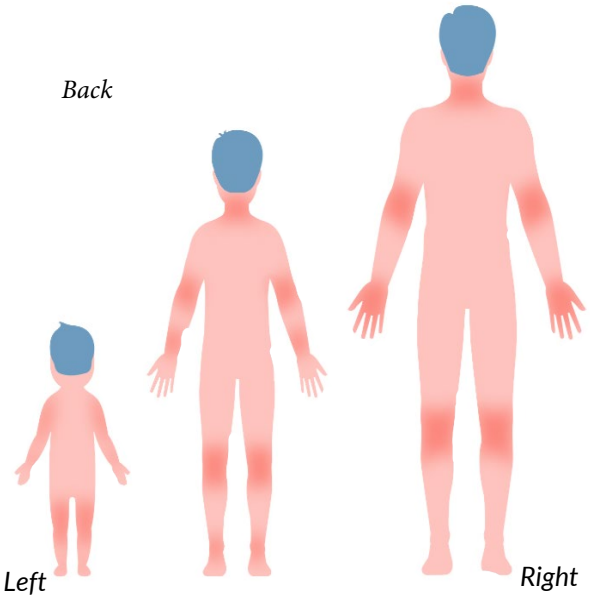
_____

_____

_____

_____

Back



Left *Right*

Suggestions for treatment based on your current symptoms and lifestyle:	Name of medication or type of treatment: emollient, humectant, lotion, cream, medication, therapy	How to use: inject, apply to skin, by mouth, etc.	Dose (mg) or length of time treatment used	Number of times daily or weekly	For relief of what symptom	Name of pharmacy
☐ Topical corticosterioid						*Refill Y / N New Y / N*
☐ Topical calcineurin inhibitor						*Refill Y / N New Y / N*
☐ Biologic						*Refill Y / N New Y / N*
☐ Wet wrap						*Refill Y / N New Y / N*
☐ Light therapy						*Refill Y / N New Y / N*
☐ Vitamin or supplement						*Refill Y / N New Y / N*
☐ Other						*Refill Y/ N New Y / N*

Contact your provider any time your symptoms increase in severity or if your symptoms have not improved before your next appointment.