



Rosacea Clinical Scorecard

Patient Name _____

Date: _____

Primary Features

Flushing (transient erythema)	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Nontransient erythema	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Papules and pustules	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Telangiectasia	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

Secondary Features

Burning or stinging	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Plaques	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Dry appearance	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Edema	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
If present:	<input type="checkbox"/> Acute	<input type="checkbox"/> Chronic		
If chronic:	<input type="checkbox"/> Pitting	<input type="checkbox"/> Nonpitting		
Ocular manifestations	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Peripheral location	<input type="checkbox"/> Absent	<input type="checkbox"/> Present		
If present:	List location(s) _____			
Phymatous changes	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Granulomatous changes	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

Global Assessment

Physician ratings by subtype

Subtype 1: Erythematotelangiectatic	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Subtype 2: Papulopustular	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Subtype 3: Phymatous	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Subtype 4: Ocular	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

Patient's global assessment Clear Mild Moderate Severe

Initial symptoms occurred: _____

Treatment prescribed: _____

Comments: _____

Physician: _____

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