Atopic Dermatitis Control Tool

Please answer the following questions thinking about your experiences with eczema, sometimes called “atopic dermatitis.”

1. Over the last week, how would you rate your eczema-related symptoms (for example, itching, dry skin, skin rash)?
   - 0 None
   - 1 Mild
   - 2 Moderate
   - 3 Severe
   - 4 Very Severe

2. Over the last week, how many days did you have intense episodes of itching because of your eczema?
   - 0 Not at all
   - 1 1-2 days
   - 2 3-4 days
   - 3 5-6 days
   - 4 Every day

3. Over the last week, how bothered have you been by your eczema?
   - 0 Not at all
   - 1 A little
   - 2 Moderately
   - 3 Very
   - 4 Extremely

4. Over the last week, how many nights did you have trouble falling or staying asleep because of your eczema?
   - 0 No nights
   - 1 1-2 nights
   - 2 3-4 nights
   - 3 5-6 nights
   - 4 Every night

5. Over the last week, how much did your eczema affect your daily activities?
   - 0 Not at all
   - 1 A little
   - 2 Moderately
   - 3 A lot
   - 4 Extremely

6. Over the last week, how much did your eczema affect your mood or emotions?
   - 0 Not at all
   - 1 A little
   - 2 Moderately
   - 3 A lot
   - 4 Extremely