

SOUTHERN HIGHLANDS ALBINISM PROGRAMME PATIENT QUESTIONNAIRE

FOLLOW UP VISIT (1/1)

DATE OF VISIT: __/__/____

PATIENT CODE:

SUN PROTECTION HABITS

Average n° daily sun hours: _____ Sunglasses? Yes No

How often did you apply the sunscreen? Check all that apply:

Morning Afternoon Evening Additional Times

Please report below your observations on Sunscreen and clothing protection as well as if you observe erythema:

	Face	Lips
Sunscreen use	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Clothing protection	<input type="radio"/> Full <input type="radio"/> Partial <input type="radio"/> None	<input type="radio"/> Full <input type="radio"/> Partial <input type="radio"/> None
Erythema	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Known	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Known
	Ears	Neck
Sunscreen use	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Clothing protection	<input type="radio"/> Full <input type="radio"/> Partial <input type="radio"/> None	<input type="radio"/> Full <input type="radio"/> Partial <input type="radio"/> None
Erythema	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Known	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Known
	Upper Limbs	Lower limbs
Sunscreen Use	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Clothing protection	<input type="radio"/> Full <input type="radio"/> Partial <input type="radio"/> None	<input type="radio"/> Full <input type="radio"/> Partial <input type="radio"/> None
Erythema	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Known	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Known

Actinic Keratosis (evaluated only in clinic distributions) Present Absent Cryotherapy done: Yes No

Suspicious malignancies: Yes No Referred: Yes No If yes, where: _____

SUNPROTECTIVE MEASURE RETURNED

No of Containers Returned: 0 1 2 3 4 5

If no containers return mark why: Forgot Lost not finished not aware others

Was the sunscreen provided sufficient? Yes No If not, how long were you without sunscreen (weeks)?

SUNPROTECTIVE MEASURE GIVEN

Name of sunscreen dispensed: Kilisun Other: _____

Sunscreen dispensed: 0 1B 2B 3B 4B 5B 1S 2S 3S 4S 5S

Batch No. of Containers dispensed: 1) _____ 2) _____ 3) _____ 4) _____

Protection elements: Hat Sunglasses Other _____

EDUCATION PROVIDED? Yes No

If education was provided, How much helpful was it on:

Albinism	<input type="radio"/> Helpful	<input type="radio"/> Indifferent	<input type="radio"/> Not helpful
Photo protection	<input type="radio"/> Helpful	<input type="radio"/> Indifferent	<input type="radio"/> Not helpful
Kilisun Use	<input type="radio"/> Helpful	<input type="radio"/> Indifferent	<input type="radio"/> Not helpful

Filled by: _____

Signature: _____

Designation: KSPU staff Consultant Dermatologist ADDV Nurse TAS leader Teacher Others