ACNE QUESTIONNAIRE

PATIENT NAME: __________________________    DATE:_____________________

1. Duration of disease: ____________________________________

2. Location of acne:  
   - Face  
   - Neck  
   - Back  
   - Chest  
   - Shoulders

3. Over the counter products used________________________________________

4. Prescription products used: 
   - Strength/kind  
   - How long?  
   - Side effects
     - Benzoyl peroxide  
     - Topical antibiotics  
     - Retin A  
     - Accutane  
     - Oral antibiotics  
     - Other

5. Do you prefer gel, lotion, solution or cream?  (circle one)

6. Present regimen:______________________________________________
   - (Cleansing &  
   - How often,  
   - Medications)

7. Skin type:     _______ dry   ___________ medium _______ oily

8. Do you have to be careful of which type of products you use or your skin becomes dry and irritated?  

9. Which products make your skin dry and /or irritated?  

10. Do you have to change your skin care routine seasonally? _____________

   Females:
   - Cyclical flare
   - Pregnant
   - Breast feeding
   - Planning a pregnancy
   - Birth control pill, type

11. Sun exposure:  Hours per week:                       Sun protection:
   - Work  
   - Recreational  
   - Purposeful  
   - Sunscreen  
   - Clothing  
   - Hat

DOCTOR TO FILL OUT

RX:                     Side Effects: Sun sensitivity
Cleanser_________  
Topical antibiotics_________  
Birth control pill_________  
Minocycline_____  Retin A_____  
Tetracycline_____  Differin_____  
Doxycycline_____  Azelex_____  
Septra_______  Finacea______  
Accutane______  

RTC:_________________