INITIAL ACNE QUESTIONNAIRE

NAME: _____DOB_____ DATE:_____Pg.____

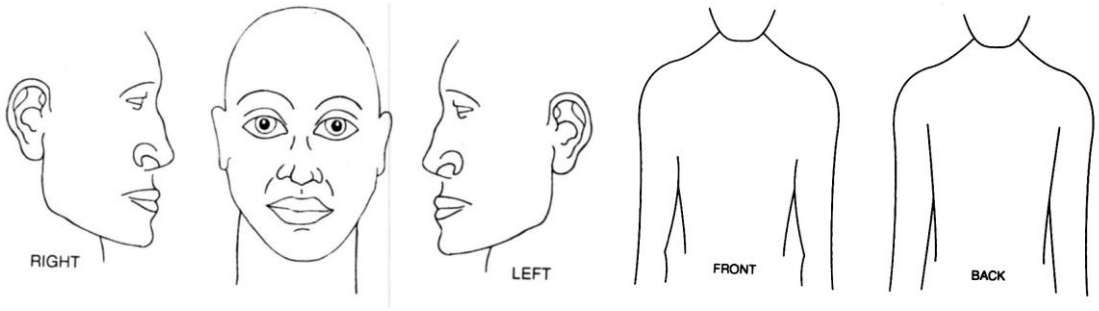
1. Duration of disease: _____
2. Location of acne: Face ____Neck _____Back _____Chest ____Shoulders_____
3. Over the counter and prescription products **EVER** used - Include Washes:

Products:	Strength	Duration/Frequency of use	Side effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. Present regimen:_____
   (Cleansing & _____
   Products) _____
5. Do you prefer gel, lotion, solution or cream? (circle one)
6. Skin type: Dry _____ medium _____ oily_____Easily irritated _____
7. Distress due to acne: Scale 1-10 (1 is Minimal, 10 is ruining my life) _____
9. Acne today: Normal___ Little better___Lots Better____Worse___ Lots Worse___
10. Anything make it worse? _____
11. Hours of Sun/week : Work_____ Recreational _____Purposeful_____
10. Sun Protection : Sunscreen/SPF#_____ Clothing _____ Hat_____

FEMALES: Cyclical flare _____Pregnant_____Breast feeding _____
Planning a pregnancy_____Birth control pill, type_____

DOCTOR TO FILL OUT BELOW THE LINE:



Digital Pictures Yes/No

1=pustules 2=inflamed papules 3/4open/closed comedones 5/6=cysts < 5 mm/>5mm 7=violaceous 8=erythema 9/10=small pits/deep pits 11=manipulation

AM Regimen_____

PM Regimen_____

_____

Patient advised improvement in 4 weeks and continuing to improve over 12 weeks.

Side Effects Discussed: Sun Sensitivity, Allergy, decreased BCP effectiveness, Irritation, GI upset_____

Initials_____RTC_____

_