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Name:_____DOB: _____

Acne Patient:

Where is the acne located?☐FACE☐ CHEST☐ BACK☐SHOULDERS
How long has the acne been present?____Days /____Weeks /____Months /____Years
Is the acne painful?☐No☐Mildly Painful☐ Moderately Painful☐ Extremely Painful
Have you noticed acne scars?☐Yes☐No
What have you treated your acne with so far?

_____
Have these previous treatments been effective? ☐ Yes ☐ No

_____
Have these products been too drying?☐Yes☐No
In addition to acne, have you noticed:☐Unwanted hair growth☐Unwanted hair loss☐Acne flaring with periods
Do you play any sports? If so, which ones? _____
How is your acne today?☐Today is a good day☐Today is an average day☐Today is a bad flare day

Female patients only:

Are you:

Currently on any form of contraception (i.e. birth control pills, IUD, shots)?☐YES☐NO

If YES, name of birth control_____

Are you:

☐Currently pregnant☐currently trying to get pregnant☐planning to get pregnant within the next year?