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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?
_____
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? _____
Do you have a family history of scarring from acne? YES/ NO
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?