HOWSDEN DERMATOLOGY 1919 S. SHILOH RD #300, LB42, GARLAND, TX 75042 TELE: 972-278-4992

PATIENT ACNE HISTORY

- **CIRCLE** age at which your acne began? **8-12** **13-15** **16-20** **>20 yrs**

- **CIRCLE** areas involved: **FACE** **NECK** **BACK** **CHEST** **SHOULDERS** **ARMS**

- If you have used **only** over the counter products, list them here:

____

- If you have had your acne treated by physicians:
  ( ) Primary Care or Family Doctor ( ) Dermatologist
  CIRCLE duration of physician treatment **<6 months** **6 months-2 yrs** **> 2yrs**
  Place an X by any product listed below that you have used:

[TOPICAL PREPARATIONS]

( ) BENZAMYCIN **( ) BENZACLIN** **( ) CLEOCIN T (TOPICAL CLINDAMYCIN)**
(GEL, SOLUTION, LOTION, PLEDGET)
( ) RETIN A (CIRCLE FORM IF KNOWN: CREAM GEL MICRO GEL SOLUTION)
( ) DIFFERIN (CIRCLE FORM IF KNOWN: CREAM GEL)
( ) AVITA **( ) AZELEX** **( ) TOPICAL ERYTHROMYCIN**
(ERYGEL, AKNE-MYCIN, EMGEL ETC.)
( ) TRIAZ **( ) KLARON LOTION** **( ) SULFACET**
( ) TAZORAC **( ) OTHER** ____________________

[SYSTEMIC MEDICATIONS]

( ) TETRACYCLINE **( ) MINOCYCLINE** **( ) DOXYCYCLINE**
( ) ERYTHROMYCIN **( ) BACTRIM OR SEPTRA** **( ) AMPICILLIN**
( ) ACCUTANE **( ) OTHER**
(IF ACCUTANE HAS BEEN TAKEN, CIRCLE WHEN: WITHIN PAST YR WITHIN PAST 3 YRS >3 YRS)

- Are you presently taking any medications? **CIRCLE** **YES** **NO**
  (If "yes", please list: ______________________________________)
- Have you had any major problem with your health in the past year or are you being treated by a physician for any illness?
  CIRCLE **YES** **NO** (If "yes" for either, explain: ____________________
  ____)

THE FOLLOWING QUESTIONS ARE FOR FEMALE PATIENTS ONLY:

- Do you take birth control pills? **CIRCLE** **YES** **NO**
  (If "yes", how long have you taken them: ____________)
- Did you stop taking birth control pills within the past year? **CIRCLE** **YES** **NO**
- Does your acne flare at the time of your menstrual period? **CIRCLE** **YES** **NO**
- Are you pregnant? **CIRCLE** **YES** **NO** (If "yes" when is your due date? ____________.)

Patient Signature: ____________________ Date: __________ Doctor's Initials: ____________