

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 SEPTA () 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: _____