Acne Questionnaire

1. How many months or years have you had acne? _________________________________

   Since that time, how has your acne been? (Circle one)        About the same        Worse        Better

2. Do you have any of the following? (Circle one)  Irregular Periods    Excess Hair Growth    Pre-diabetes

3. Have you tried any prescription acne medications? (Circle one)    YES      NO

   If YES, please list all the medications you have tried AND how long you used each medication:
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

4. Please list ALL skin care products you are using on your face, including soaps, cleansers, moisturizers, make-up, and any over the counter acne products you are currently using:
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

5. Which type of skin do you have? (Circle one)       DRY      NORMAL      OILY      VERY OILY

6. How much does your acne bother you? (Circle one) NOT AT ALL      SOMEWHAT      VERY MUCH

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PATIENT SIGNATURE