Name: _____

Date: _____

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

_____

PATIENT SIGNATURE