PATIENT ACNE HISTORY

NAME _____ S.S. # _____ DATE OF BIRTH _____ DATE _____

ADDRESS _____ AGE _____ SEX _____
Street City State Zip

LIST YOUR PRESENT ACNE THERAPY: Soaps _____

Lotions _____ Pills _____

What age did your acne begin? _____ Is it (circle) progressing or improving?

Have you been treating it yourself, using non-prescription items? Yes _____ No _____

NAME OF PRODUCTS — IMPROVEMENT

_____ NONE SOME A GREAT DEAL

_____ NONE SOME A GREAT DEAL

Did you try any other type of self treatment? (Washing, diet, sun-lamp, etc?) Yes _____ No _____

If yes, please indicate which were tried and if effective.

TREATMENTS — IMPROVEMENT

_____ NONE SOME A GREAT DEAL

_____ NONE SOME A GREAT DEAL

Have you ever had your acne treated by a physician? Yes _____ No _____

Were topical treatments (cleansers, medicated soaps, cream, etc.) prescribed? Yes _____ No _____

TREATMENTS — IMPROVEMENT

Vitamin A Acid (Retin-A) Yes _____ No _____ NONE SOME A GREAT DEAL

Benzoyl Peroxide Yes _____ No _____ NONE SOME A GREAT DEAL

(Panoxyl, Desquam-X, Oxy 5)

OTHERS

_____ NONE SOME A GREAT DEAL

Were oral antibiotics prescribed? Yes _____ No _____

NAME — IMPROVEMENT

Tetracycline Yes _____ No _____ NONE SOME A GREAT DEAL

(Achromycin, Panmycin, Sumycin, etc.)

OTHERS

_____ NONE SOME A GREAT DEAL

_____ NONE SOME A GREAT DEAL

Were birth control pills prescribed as a treatment for acne? Yes _____ No _____

NAME — IMPROVEMENT

_____ NONE SOME A GREAT DEAL

Have birth control pills made your acne (circle) BETTER OR WORSE

NAME — IMPROVEMENT

_____ NONE SOME A GREAT DEAL