Were any of the following tried?

			IMPROVEMENT		
Special Diets	Yes _____	No _____	NONE	SOME	A GREAT DEAL
Ultraviolet Light	Yes _____	No _____	NONE	SOME	A GREAT DEAL
Acid or dry ice peels	Yes _____	No _____	NONE	SOME	A GREAT DEAL
Injection into cysts	Yes _____	No _____	NONE	SOME	A GREAT DEAL

LIST ANY OTHER TREATMENTS OR REGIMENS NOT SPECIFICALLY MENTIONED:

TREATMENT	IMPROVEMENT		
_____	NONE	SOME	A GREAT DEAL
_____	NONE	SOME	A GREAT DEAL

LIST ANY SPECIAL DIET RECOMMENDED:

TYPE	IMPROVEMENT		
_____	NONE	SOME	A GREAT DEAL
_____	NONE	SOME	A GREAT DEAL

What facial cosmetics do you use? (cover-ups, moisturizers, pressed powders)

_____

_____

_____

Have facial cosmetics made your acne: (circle) BETTER OR WORSE

NAME	IMPROVEMENT		
_____	NONE	SOME	A GREAT DEAL
_____	NONE	SOME	A GREAT DEAL

Do you find your acne is related to stress? Yes _____ No _____

If yes, please circle the source(s) of stress which have the greatest adverse effect on your acne.

School Work Home Life Pre-Menstrual Pregnancy Sickness Legal Other

COMMENT: _____

_____

Has acne affected you emotionally and socially? Yes _____ No _____

COMMENT: _____

_____

DO YOU HAVE ANY SERIOUS ILLNESSES? Yes _____ No _____

Diabetes?

Heart Disease?

Epilepsy?

Mental Illness?

Other: _____

DO YOU HAVE ANY ALLERGIES? Yes _____ No _____

Asthma or hay fever?

Drug allergies, such as penicillin?

ARE YOU TAKING ANY MEDICATIONS? Yes _____ No _____

List: _____