Patient's name and DOB: Today's date:

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Acne questionnaire for new patients:

1. How long have you had your acne (weeks, months, years)?
2. What parts of your body are affected?: face chest back shoulders neck
3. What parts of your body that are affected bother you enough to treat? Face chest back shoulders neck
4. Does it affect your mood or daily functioning/activities? If so, how?
5. Has it ever been treated with OTC meds? Did you use them regularly for at least 3 months? If so, which ones, and how did you react?
6. Has it ever been treated with Rx meds? Did you use them regularly for at least 2 months? If so, which ones, and how did you react?
7. Have you ever taken Accutane/isotretinoin? When? How much? What was your response? Did you have side effects?
8. Where do you go to school/work?
9. Are you under significant stress?
10. When do you usually go to bed?
11. When do you usually wake up?
12. Is your sleep routine pretty regular, or does it change from day to day, or on the weekends?
13. Do you drink cow's milk? How much? How often? Use it in your cereal or coffee regularly? Do you buy hormone-free milk?
14. Do you drink: juice, soda, sweetened iced tea/hot tea/coffee, lemonade, sports drinks? How much and how often?
15. Do you eat sweets, like candy, cookies, cakes, frozen desserts? How often?
16. What do you typically eat for breakfast?:
17. What do you typically eat for lunch?:
18. What do you typically eat for dinner?:
19. How many fruits do you eat on a typical day?
20. How many servings of vegetables do you eat on a typical day?
21. Whole wheat or white breads/rolls/pasta?
22. White rice or brown rice?
23. Do you eat: fish, beans, whole grains, nuts, seeds, legumes like peanuts/lentils, avocados, olive oil?
24. How much alcohol do you consume per week: number of drinks X number of times per week = ??
25. Do you smoke cigarettes/cigar/pipe? Chew tobacco?
26. Do you smoke pot/ingest pot in any way on a regular basis?
27. Are you generally a healthy person?
28. Do you take any prescription meds? Steroids? Antibiotics? Testosterone?
29. Do you use any recreational drugs? Which ones and how often?
30. Do you ski? Do you get a lot of sun exposure? How do you spend your summers?

31. Is there a family history of significant acne in your parents or siblings? Has anyone in your family taken Accutane/isotretinoin?
32. Do you pick at or squeeze your acne?
33. Do you wash your face? If so, how often and with what soap/cleanser?
34. Do you normally moisturize your face? Use any hair oils/conditioners?
35. Do you generally wear sunblock daily? As needed? Not at all?
36. Do you have any allergies or intolerances to medications, even over-the-counter topical medications (eg. Benzoyl peroxide)?
37. Would you say you have sensitive skin?
38. Do you take body-building supplements? Whey protein?
39. Do you notice anything that makes your acne worse?
40. Do you notice anything that makes your acne better?

For girls and women only:

1. Are you menstruating?
2. At what age did you start?
3. Are you (possibly) pregnant? How far along? How has your skin reacted to the pregnancy?
4. Nursing? How long do you intend to continue?
5. Trying to become pregnant?
6. Are your periods regular? Heavy? Painful?
7. Does your acne flare up in association with your menstrual cycle? If so, how so?
8. Do you have excessive body/facial hair? Thinning scalp hair?
9. Do you carry a diagnosis of polycystic ovaries or any other hormonal disturbances?
10. Are you currently sexually active and if so, do you use contraceptives? If so, which one(s)?
11. Are you on birth control pills or any other hormones, or do you have a hormonal IUD? How long, and does it seem to affect your skin?
12. Have you ever been on birth control pills, and if so, which one(s), how long, and how did it affect your skin?
13. Do you have a history of infertility or difficulty becoming pregnant?
14. Do you normally wear makeup? If so, which one? Does it work well enough to hide your acne?
15. Do you have any reason why you cannot take birth control pills: history of : blood clot in you or in a close family member, arterial disease or valvular heart disease, high blood pressure, diabetes with vascular complications, migraine headaches with focal neurological symptoms, immobilitization, breast or endometrial/uterine cancer, abnormal vaginal bleeding, liver disease, smoking, over age 35 years, allergy to ingredients, genetic defects/diseases/drugs/antibodies known to increase your risk of blood clots?