

ACNE CONSULT INTAKE FORM

Name _____ Date _____

At what age did you start having problems with acne? _____

How would you characterize your **CURRENT** breakout, compared to your acne in general?

- _____ Less severe than usual
- _____ Same as usual
- _____ Worse than usual

Where do you usually break out?

- _____ Face
- _____ Back
- _____ Chest
- _____ Other _____

Does your acne have any of the following characteristics?

- _____ Red and inflamed
- _____ Cystic (deep, painful bumps)
- _____ Blackheads
- _____ Whiteheads

Medication History:

Do you take a multivitamin? YES / NO

Have you been prescribed antibiotics for your acne? YES / NO

If YES, when? _____ Which one(s)? _____

Have you ever been prescribed Accutane? YES / NO If YES, when? _____

For Females:

Have you ever been on birth control pills? YES / NO

If YES, when? _____ If YES, which one(s)? _____

Skin Care:

How often do you wash your face? _____

What do you use to wash your face? _____

What other products do you use on your skin?

- _____ Toner
- _____ Moisturizer
- _____ Topical acne treatments
- _____ If YES, which one(s)? _____
- _____ Other _____

Do you participate in sports? YES / NO If YES, which one(s)? _____

Diet (Please check those that are part of your regular diet):

- _____ Milk _____ Juice _____ Water _____ Soda _____ Cheese _____ Soy products
- _____ Creatine or Protein