Acne Patient Questionnaire

Patient name: _____ Date: _____

1a. How long have you had acne?

1b. *Females Only*: Do you have regular monthly periods?
❑ Yes ❑ No

Do you break out worse during or around your period?
❑ Yes ❑ No

If Yes circle how bad your breakouts around your period are:
❑ mild ❑ moderate ❑ severe

2. What non-prescription, over-the-counter products are you using now for your acne? This includes cleansers and moisturizers.

3. What prescription products have you used now and in the past? Did they work? Did you have any side effects like dry skin or allergic reactions? Please provide details below.

4. Check the skin type you have:
❑ Very oily ❑ Oily ❑ Normal ❑ Dry ❑ Very dry ❑ Sensitive ❑ Combination
If sensitive, what is your skin sensitive to?

5. On a scale of 1-10, how do you rate the amount of stress your acne causes you (10 being extremely stressful)?
❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

6. Are there any particular acne treatments that you are interested in discussing today?
❑ Microdermabrasions ❑ Chemical peels ❑ Accutane/Isotretinoin
❑ Antibiotics ❑ Scar treatment/lightening ❑ Other

7. Please check any of the following acne related concerns you would like to discuss today:
❑ Acne scars ❑ Discoloration ❑ Painful acne cysts ❑ Oily skin ❑ Blackheads

8. I will need to achieve a minimum __% improvement to consider my acne treatment a success.
❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

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