Oregon Dermatology and Research Center  
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Acne Questionnaire

Name: ___________________________________ Age: _____ Sex: M or F Date: __________

At what age did your acne begin? _______ Do other family members have acne? _______

What is your skin type? Oily___ Dry___ Combination___

Which areas of your skin are affected? Face___ Neck___ Chest___ Back___

What over-the-counter medications have you tried?
  Salicylic acid___
  Benzoyl Peroxide___
  Proactive___
  Other ____________________________

When did you try these medications?________________________ Were they helpful? __________

If not, did they irritate your skin? ____________________________________________________

What Topical medications have you tried?
  Retin A___ Differin___
  Cleocin___ Benzoyl Peroxide___
  Klaron___ Azelex___
  Benzaclin___ Duac___
  Sulfur products___ Other ____________________________

When did you try these medications?________________________ Were they helpful? __________

If not, did they irritate your skin? ____________________________________________________

What Oral medications (pills) have you tried?
  Tetracycline___
  Minocycline___
  Doxycycline___
  Accutane___
  Other ____________________________

When did you try these medications?________________________ Were they helpful? __________

Did you have any side effects from these medications? __________________________________

What other medications are you currently taking? ________________________________________

Please list the brands of products you are currently using on your face:
Soap/cleansers

Moisturizer/Sunscreen

Foundation

Concealer

Astringent/toner

Other

*Please list the leave-in products that you are currently using on your hair:*

Styling products

**Does exercise make your acne worse?** __________ **Are your breakouts stress related?** ________________

**What do you think is causing or exacerbating your breakouts?** __________________________________________

**What makes your acne better?** _______________________________________________________________ 

**Women:**

If you take birth control, which one

**How long have been taking it?** __________________________ **Are you pregnant?** ______ Postmenopausal? ______

**Are your periods regular?** ______ If not, what is your cycle like ________________________________________

**Does your acne flare up around time of menstruation?** ______ **Other hormonal concerns?** ________________