

Oregon Dermatology and Research Center

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Acne Questionnaire

Name: _____ Age: _____ Date: _____

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

What medication/products have you tried for your acne?

When did you try these medications? _____ Were they helpful? _____

Did they irritate your skin? _____

What topical medications have you tried (tretinoin, adapalene, clindamycin, sulfur etc)?

When did you try these medications? _____ Were they helpful? _____

Did they irritate your skin? _____

What oral medications have you tried (antibiotics (doxycycline, minocycline) isotretinoin, hormones)?

When did you try these medications? _____ Were they helpful? _____

Did you have any side effects from these medications? _____

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?* _____