ACNE INSTITUTE of OMAHA

Patient Label

Patient Background Information

Background Questions:

1. How long have you had acne? _____

2. In which areas do you have acne? (circle all that apply)

Scalp Face Neck Chest Back Arms Shoulders Other_____

3. What is your current treatment plan, or routine? (please note if and which cleanser used and how many times daily you wash the areas). _____

_____

4. What previous prescription or over-the-counter treatments have you used? (please note if they helped)

_____

_____

5. Is there anything that makes your acne worse? _____

6. Your past medical history: (circle all that apply)

Crohn's Colitis Diabetes Depression/Anxiety/Other psychological disease none of these

FEMALES ONLY

7. Are you pregnant or planning to become pregnant in the next 12 months? Y N

8. Are you currently breastfeeding? Y N

9. Current medications: _____

10. Medication Allergies: _____

11. Family History (circle all that apply)

Acne Eczema Psoriasis Crohn's Colitis Depression/Anxiety/Other psychological disease none of these

12. Have you had any of the following recently?

Diarrhea Mood changes Depression