

LAST	FIRST	LOV ACNE W M Y	HO	ACC BY	
NN	AGE	EP NP	ACNE X2 NONE	RELATIONSHIP	
DATE STAMP					

## ACNE FOLLOW-UP

Since your LAST visit on \_\_\_\_\_, describe your progress (circle):

Clear ----- Almost Clear ----- Better ----- Slightly Better ----- No change ----- Slightly Worse ----- Much Worse

Comments about your progress:

Since your LAST visit, list EVERY product you have used for or on your acne areas (OTC and Rx):

PRODUCT NAME	TYPE E.g. pill, cleanser, gel, cream	HOW OFTEN? E.g. every AM, every PM etc	STARTED WHEN?	LAST USED?	Any Problems?	Dur	Off x

### Acne Extractions

Are you doing?	How often?	How many each session?	Explain any problems:	
Yes No				

Any other concerns:

-----Do not write below this line-----

	O/C	P/P	Comments
Face:			
Chest:			
Back:			
Other			

PLAN:

HO:  
Acne top  
Acne gen  
Isotret