Elizabeth M. Vennos, M.D.

ACNE
New

LAST	FIRST	LOV ACNE D W M Y	HO MC SC WARTS ACNE X2 PS NONE	ACC BY	CHECK IN BY
NN	YO	EP NP		RELATIONSHIP	G CARD Y N
DATE STAMP					

--Do not write above this line--

How long ago did you first notice **any** significant acne?	___________years_________months	
What areas are you concerned about? (check)	❑ Face ❑ Chest ❑ Back ❑ Other Area(s):	
Please rank how severe your acne is **today,** compared with how it has been over the last ***year.*** (circle)	Compared to the last year, ***today*** you are a: Best 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10 Worst	

Please list **all treatments**, in the table below, which you have tried in for your acne. All **Rx and OTC**

PRODUCT NAME	TYPE Eg. pills, cleansers, gels, creams	HOW OFTEN? Eg every AM, every PM etc	STARTED WHEN?	LAST USED?	Any Problems?	Any benefit?	Dur	Off x

Circle any of these products you have ever used (Give details in table above):

Retin A – Differin – Tazorac --- Benzoyl Peroxide -- Minocycline pills –Tetracycline pills- - Accutane pills – Other antibiotic

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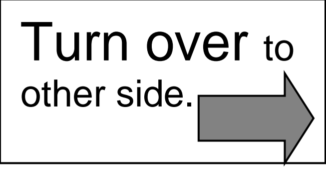

	O/C	P/P	Comments
Face:			
Chest:			
Back:			

PLAN:

Any thing else you want the doctor to know about your acne?

FEMALES ONLY:

Have you noticed more **body or facial hair** than what you think is normal for women in your family?	❑ No	❑ Yes	If "yes", which skin areas?	
Do you have **irregular** menstrual cycles?	❑ No	❑ Yes	If "yes", how many did you have in the last 12 months?	
Have you ever had any **hormone** blood tests?	❑ No	❑ Yes	Date: Result: Doctor who ordered test:	
Have you ever used these **birth control** products : Birth control pills, Estrogen ring Norplant Depo Provera	❑ No	❑ Yes	If "yes", Brand name of medication: First used: Last used:	
Does your acne worsen at certain times during your menstrual cycle?	❑ No	❑ Yes	If "yes", explain:	