

Dermatology of the Berkshires, P.C.

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NEW ACNE PATIENT

Name: _____ DOB: _____ Date: _____

How long has acne been present? _____

What area is affected? (please circle) face, neck, chest, back, shoulders

Is there a family history of acne? (brothers, sisters, parents) Scarring? _____

Is acne worse with stress? _____

FOR GIRLS:

What age did menses start: _____

Are menses regular? _____

Is acne worse with your period? _____

Please list any prescription medications, pills or creams you have taken for your acne: _____

Please list any over the counter medications (like Benzoyl-Peroxide or Pro-active) that you have tried: _____

Please list any soaps, moisturizers or other skin care products you use on your face: _____

Please list any hair sprays, gels, or mousses you use: _____

Do you consider your skin to be dry, oily or normal? _____