

Patient: _____

Date: _____



Alpine Dermatology Associates, P.L.L.C.

ACNE HISTORY

We would like to give you the best possible treatment for your acne. Please answer the following questions so we can give you the correct treatment for your skin.

1. How old were you when you first started to have acne? _____
2. Did you have acne in your teens? ____Yes ____No
3. How long have you had acne? _____
4. Any family history of acne? ____Yes ____No If yes, please describe: _____

5. Any previous treatment for acne by a doctor? ____Yes ____No
6. Any previous treatments for acne by a dermatologist? ____Yes ____No
7. Any of the following treatments? ____Light treatments ____X-ray treatments
____Acne surgery ____Cryotherapy ____Chemical peels ____Microdermabrasion
8. What have you used to treat your acne in the past?
 - a. Names of medications used on skin: _____
 - b. Names of oral medications (taken by mouth): _____
9. What is your current skin care regimen?
 - a. How many times a day do you wash your face? _____
 - b. Name of soap: _____
 - c. Names of sunscreens: _____
 - d. Names of makeup: _____
 - e. Names of astringents: _____
 - f. Names of moisturizers: _____
 - g. Other (mask/scrubs/etc.): _____
10. My skin is: ____Dry ____Sensitive ____Oily ____Combination ____Normal
11. Are you out in the sun very much? ____Yes ____No If yes, please describe: _____

12. Any exposure to oily/greasy environment? ____Yes ____No If yes, please describe: _____

13. Occupation: _____

14. Are you under increased stress at home, work, or school? Yes No If yes, please describe: _____

15. If you are female, please answer the following:

a. Do you have menstrual periods? Yes No

If yes, are they regular? Yes No

b. Are you pregnant? Yes No Due Date: _____

c. Does your acne get worse: Before menses During menses After menses

d. Have you had any gynecological surgeries? Yes No

If yes, please describe: _____

e. Hormones or birth control pills: Yes No

f. Hormone shots: Yes No

g. Have you had any hormone tests done? Yes No When? _____

h. Excess hair growth? (beard, mustache, arms, body) Yes No

i. Thinning scalp hair? Yes No

**PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR
APPOINTMENT AT ALPINE DERMATOLOGY**

THANK YOU!