QUESTIONNAIRE: Acne

Name _____ *Date of birth* _____

1. What areas are affected? Face / Chest / Back
2. Are you getting cystic lesions? Yes / No
3. Do you flare with menstruation? Yes / No / NA
4. Are you pregnant or breastfeeding? Yes / No
5. What products have you tried? _____
6. What products have seemed to help? _____
7. What is the name of the wash you use for any acne affected areas? _____
8. What is the name of the moisturizer you use for any acne affected areas? _____
9. What are your feelings about Accutane (check one)?
   - ☐ Never heard of it and/or want to learn more
   - ☐ Ready to start today
   - ☐ Would never take it
10. If you answered "would never take it" in #9, please explain why _____
11. What else would you like the doctor to know? _____

Erin Ducharme, MD, FAAD
16349 Sheridan Ave, Suite 101 • Clive, IA 50325
(515) 987-0333