Name_____
Date _____

Comprehensive Patient Acne Assessment

Current age _____ Age at which acne appeared / worsened _____
Degree of acne (circle one): mild moderate severe
Today, the acne is: better worse same as usual
Location of acne: back chest neck shoulders chin cheeks nose forehead
Is your face? oily dry sensitive (easily irritated) normal combination
Acne flares with: stress diet exercise / sweat other_____
Has any sibling or parent had severe acne (if so, who)? _____
Stress level: none 1 2 3 4 5 6 7 8 9 10 unbearable
Cause of stress_____
Sleep: hours per night_____ Interruptions per night _____
Do you go to sleep on a regular schedule (i.e. 10 p.m. every night)? _____
How much does acne affect you emotionally? Not bothered 1 2 3 4 5 6 7 8 9 10 unbearable
Exercise: Strength training times per week _____ duration _____
Flexibility times per week _____ duration _____
Cardiovascular times per week _____ duration _____
Are you involved in any sports? _____
Current acne treatments: _____
Previous treatments (please note if they helped or not, if possible) _____
_____
_____
Are you interested in?
____Topical creams / lotions only ____Natural options ____More aggressive therapy (pills)
Any other acne concerns?_____

Any problems with constipation? _____
Typical diet (please include ALL food consumed in one day and PLEASE be honest):
Breakfast _____
Snack _____
Lunch _____
Snack _____
Dinner _____
Snack _____

Cups per day:
Milk _____ Fruit juice _____ Coffee _____
Soda _____ Gatorade / G2 _____ Tea _____

Women Only:
Any current birth control pills (brand)? _____
Do you have unwanted facial hair? _____
Menstrual cycle: regular irregular absent, due to _____
Does your acne flare depending on your cycle? _____