

Acne/Rosacea Intake Questionnaire

When did you start to notice your acne/rosacea?

Do you have a family history of acne/rosacea? **YES NO**

Where is it located?

What type of acne do you have:

Whiteheads/Blackheads, Inflammatory papules, Scarring, Redness/Flushing, Scaling

What over the counter products have you tried for your acne/rosacea?

Salicylic Acid Benzoyl Peroxide Sulfur Other:

What prescription medications have you tried or recently used for you acne/rosacea?

Oral Medications:

Topical Treatments:

If you stopped any of the prescription medications when did you stop them and how long did you use them?

Are you taking any:

Birth Control Steroids Lithium DHEA

Do you have sensitive skin? **YES NO**

Is your menstrual cycle regular? **YES NO**

What is the date of your last period?

Is your acne/rosacea worst premenstrually? **YES NO**

Have you tried any other treatments such as:

Chemical peels (what type)

Laser treatments (what type and how many treatments)

Facials Microdermabrasion Steroid injections

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Hours:
Monday:
12:00 pm - 7:00 pm
Tuesday - Friday:
8:00 am - 5:00 pm