Dermatology of the Berkshires pc
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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? ________________________________________________