ACNE HISTORY

Client Name: _____

If you are seeking help with your acne condition, please complete this form in addition to the Client Intake Questionnaire.

A. Family Acne History
Put a check next to any relatives who have (or had) acne. If more than one, indicate the number.
none ____ sister(s) ____ father ____uncle(s) ____
brother(s) ____ grandparents ____ mother____ aunt(s) ____

B. Your History
1. At what age did your acne begin? _____

2. Is your acne . . . worsening ___improving ___ staying the same _____

C. Self-Treatment
List below any self-treatments you have every used for your acne. Name treatment at left, i.e. ProActive. Under "Improvement" column, indicate how effective the treatment was. (If your acne worsened, circle "worse.") In the far right column, indicate whether it was a past effort or a current one (using it now.)

1. Products (list name brand) Treatment Improvement Status
_____ worse ___ none ___ some ___ good ___ past ___ current ___
_____ worse ___ none ___ some ___ good ___ past ___ current ___
_____ worse ___ none ___ some ___ good ___ past ___ current ___
_____ worse ___ none ___ some ___ good ___ past ___ current ___

D. Medically Supervised Treatment
1. Have you ever had acne treatment by a physician? Yes ___ No ___

2. If yes, fill out the following treatment information by making a check beside any treatments below that have been tried on you. Then rate its effectiveness as you did above.

Treatment	Improvement Status
Vitamin A acid (Retin-A)	worse ___ none ___ some ___ good ___ past ___ current ___
Benzol Peroxide	worse ___ none ___ some ___ good ___ past ___ current ___
(PanOxyl, Desquam-X)	worse ___ none ___ some ___ good ___ past ___ current ___
(Sulphur, salicylic lotion)	worse ___ none ___ some ___ good ___ past ___ current ___
Oral or Topical Antibiotics	worse ___ none ___ some ___ good ___ past ___ current ___
Special Diets (list types) _____	worse ___ none ___ some ___ good ___ past ___ current ___
Ultraviolet light	worse ___ none ___ some ___ good ___ past ___ current ___
Dry ice peels	worse ___ none ___ some ___ good ___ past ___ current ___
Chemical peels	worse ___ none ___ some ___ good ___ past ___ current ___
Injections into cysts	worse ___ none ___ some ___ good ___ past ___ current ___
Special soaps	worse ___ none ___ some ___ good ___ past ___ current ___
Other _____	worse ___ none ___ some ___ good ___ past ___ current ___

E. Women Only (Please elaborate on the questions responded to in the Client Intake Form.)

1. Does your acne flare ups follow a monthly pattern? Yes ___ No ___

2. If so, when does the flare up occur? during menstrual period ___ at mid-point of cycle ___ week before period___

3. Do you experience any of the following (check all that apply): painful periods ___irregular periods ___ fewer than 8 periods per year ___

4. Have you been diagnosed (or suspect you may have) any of the following:
STDs ___Candida ___ Viral/Bacterial Vaginitis ___ Endometriosis ___ Uterine Fibroids ___ PCOS (Polycystic Ovarian Disease) ___ PID (Pelvic Inflammatory Disease) ___

F. Other Factors
1. Do you find your acne is related to stress? Yes ___ No ___
If yes, please check the source(s) of stress that have the greatest adverse effect on your acne.
School/Work ___ Relating to friends ___ Financial problems ___
Home life ___ Premenstrual tension ___ Legal problems ___
Marital problems ___ Illness ___ Other _____

2. Describe your sleep patterns.
How many hours sleep do you average per night? _____
Time you usually go to bed? _____ Time you usually get up. _____

3. Do you engage in competitive sports? If yes, what?
_____

4. Do you work around chemicals or oils? Yes ___ No ___
If so, what? _____

5. Do you regularly visit another climate? If so is it hot, humid, dry, sunny? _____

6. Do you notice flare-ups when you go to a different climate? Yes ___ No ___

7. Does sun exposure make your acne worse ___better ___ never noticed ___

8. Check any of the following that regularly touch your face, back or any other area affected by acne:
Headband ___ Chin strap ___ Backpack ___ Hands on chin ___ Hat ___ Tight clothing ___ Glasses ___ Other ___

G. Picking Habits
1. Do you squeeze, pop or otherwise manipulate your pimples? *Be honest!* Yes ___ No ___

2. If yes, do you squeeze or pick . . . almost every day ___ once or twice a week ___ seldom ___

3. How do you pick? squeeze with my fingers/fingernails ___ scratch with my fingernails ___ with an extractor ___ open with a needle then squeeze ___

4. When you squeeze, do you . . . usually get contents out ___ seldom get anything out ___

5. Check the statement that most applies to you.
I tend to pick deliberately in front of a mirror ___
I pick unconsciously, not noticing until later ___

6. If deliberately, when are you most likely to pick? when washing my face ___ whenever I look in a mirror ___

other _____

7. If unconsciously, when is most likely? while watching tv ___ whenever I feel nervous ___ in bed before falling asleep ___ other_____

J. Diet & Exercise
1. Are you now, or have you recently, been on a diet? Yes ___ No ___

2. If the diet was required as a medical treatment, what is, or was, being treated.
_____

3. Do you exercise regularly? Yes ___ No ___

4. If yes, please name your primary forms of exercise and frequency:
_____ _____ times per _____ for _____ minutes
_____ _____ times per _____ for _____ minutes
_____ _____ times per _____ for _____ minutes

K. Emotional State
1. Has acne affected your life emotionally or socially? Yes ___ No ___

2. Please check any statement below that applies to you.
Acne causes me to feel depressed quite often ___
Acne causes me to feel depressed only occasionally ___
I don't date or socialize because of my acne ___
I sometimes call off social engagements when I flare up ___
Even though my acne makes me self-conscious, I never cancel plans because of it ___
I do not avoid people because of my acne ___
I have trouble looking people in the eye when I talk to them ___
I avoid public contact jobs ___
I act cheerful and outgoing so people will notice my acne less ___
I don't believe my acne affects my social relationships at all ___
I get angry if other people tease or question me about my acne ___
I joke about my acne in front of my friends ___
I feel that people stare at me ___
I resent my parents' (spouse or other family member's) concern about my acne ___
My acne makes me hostile to other people ___
I've learned to live with my acne. It doesn't really bother me ___
I hate to look in the mirror ___
My boyfriend (girlfriend or spouse) doesn't seem to notice my acne ___
I break out when other people (family, friends) hassle me ___
I don't consider my acne unusual ___
I don't think other people judge me because of my acne ___

3. Any other comment you'd like to make about acne's emotional effect on you? _____

_____

I. Benzoyl Peroxide Preview
Fill out this section if you've ever used an acne product containing benzoyl peroxide, whether it was a prescription or OTC product.

1. Name of product _____

2. Percentage of benzoyl peroxide it contained _____

3. How many hours did you leave it on at each application? _____

4. How often did you apply it? more than once a day ___ once a day___ 3 times per week ___ other ___
5. Did you experience a burning sensation? Yes ___ No ___

If so, when? when I first put it on ___ continuing as long as I kept it on ___

6. Put a check by any other effects. itching ___ soreness ___ peeling ___ redness ___ flaking ___ other_____

7. How many days did you use it before you noticed peeling? _____

8. Did the above effects go away with time? Yes ___ No ___

9. Did you discontinue use of the product because of any of the effects above? Yes ___ No ___

10. Did you experience clearing from the benzol peroxide use? Yes ___ No ___

11. Did you develop an allergy to benzol peroxide? Yes ___ No ___

12. If no, how long did it take before you noticed clearing? _____

13. Do you dye your hair (or use any product with peroxide in it? Yes No

M. Skin Oiliness
1. Do you consider your skin . . . oily ___ combination ___ dry ___

Please be assured that the foregoing information is confidential and for the sole use of the Esthetician treating your skin condition.

Client Signature/Date

_____

Esthetician Signature

_____