ACNE CENTER OF MICHIGAN

Craig Singer MD Dermatology, PLLC
31000 Telegraph Road Suite 260 Bingham Farms, MI 48025
Phone: (248)792-3785 Fax: (248)792-2935

NEW PATIENT HISTORY FORM

Acne History

Name: _____

When did your acne start? _____

Where is your acne located? (Circle All): Face Chest Back Other_____

Which describes your acne? It's getting worse __ It's just not going away __

Other_____

What type of acne do you have? (Circle All):

Blocked pores Blackheads Pimples Zits Underground bumps

How often do you get new acne pimples? (e.g., every day, monthly, etc.)

_____

How much does the acne bother you (Circle One)?

A little A lot I'm devastated

Do you get **dark spots** from acne? YES _____ NO_____

Do you get **red spots from** acne? YES _____ NO_____

How do you describe your skin type? *Dry Oily Combination Not sure*

Is your skin sensitive or easily irritated? YES _____ NO_____ Not sure____

What facial cleanser do you use? _____

How many times a day do you wash your face? _____

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Which **over the counter** acne products do you use?

_____

Which **prescription** acne products are you using?

_____

Have you taken antibiotics by mouth for acne? YES _____ NO_____

If YES, which ones? _____

Have you ever taken Accutane before? YES _____ NO_____

Have any family members ever taken Accutane? YES ___ NO___ Not Sure__

Do you have scars from your acne? YES _____ NO_____ Not Sure_____

Have you ever had any treatment for acne scarring? YES _____ NO_____

If YES, what kind of scar treatments? _____

For **Females** only:

Are you pregnant or trying to get pregnant? YES _____ NO_____

Do you menstruate every month? YES ___ NO____ Other ____

Explain _____

Do you take birth control pills, use condoms, have an implant or IUD?

YES ___ NO___ Explain_____

Have you ever taken spironolactone? YES _____ NO_____

Do you have excessive hair growth on your face, chest, or belly?

YES ___ NO____ Explain_____

Have you ever been diagnosed with polycystic ovarian disease (PCOS)?

YES _____ NO_____Explain_____

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Medical History

For Men and Women:

Please circle any medical conditions that you currently have: -If none, circle **NONE**

Anxiety	Hearing Loss
Arthritis	Hepatitis
Asthma/Seasonal Allergies	Hypertension
Atrial Fibrillation (Irregular Heartbeat)	HIV / AIDS
BPH (prostate enlargement)	High cholesterol
Bone Marrow Transplantation	Hyperthyroidism
Breast Cancer	Hypothyroidism
Colon Cancer	Leukemia
COPD	Lung Cancer
Coronary Artery Disease	Lymphoma
Depression	Prostate Cancer
Diabetes	Radiation Treatment
End Stage Renal Disease	Seizures
GERD (reflux)	Stroke

Other (please explain) _____

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Skin disease History:

Have you had any of the following skin conditions (please circle)? If none, circle **NONE**

Actinic Keratosis (pre-cancer)

Basal Cell Skin Cancer

Blistering Sunburns

Dry Skin

Eczema

Other (please explain)

Flaking or Itchy Scalp

Melanoma

Poison Ivy

Precancerous (atypical/dysplastic) Moles

Psoriasis

Squamous cell skin cancer

Medications:

Please list your medications and supplements (Include OTC products like aspirin, ibuprofen, Tylenol). _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? Yes / No

If Yes, please list the date or year you had the reaction and what kind of symptoms you had, such as rash, itching, hives, shortness of breath, nausea, etc.

_____

Social History: (please circle all that apply) If none, circle **NONE**

Currently smoke cigarettes Smoked in past Recreational drug use

How many alcohol containing drinks do you have in a week? ____

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Cautions/Alerts: (please circle all that apply)

Have you ever had difficulty stopping bleeding?	Yes	No
Do you require antibiotics prior to a surgical procedure?	Yes	No
Have you had an artificial joint replaced?	Yes	No
If yes, when and what body locations? _____		
Do you have an artificial heart valve?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No

Review of systems

Circle any symptoms that you have. If you have none, then circle **NONE**

Abdominal pain / Anxiety / Bloody stool / Bloody urine / Blurry vision

Changing mole / Chest pain / Cough/ Depression / Fever or chills / Headaches /

Hay fever/ Joint aches/ Muscle weakness / Neck stiffness/ Night sweats / Rash /

Seizures / Shortness of breath/ Sore throat/ Thyroid problems / Unintentional

weight loss / Wheezing / Keloids

Pharmacy and Referral

How did you hear about our office? Explain _____

Were you referred by a physician? YES/NO

If yes, what is the physicians name? _____

What is your preferred pharmacy? (Name and city)

_____