porespective™
ACNE CONTROL

Name_____Age_____DOB_____

Address_____City_____State____Zip _____

Cell Phone/Text:_____ Email to confirm appointments:_____

**Prescribed, Over the Counter and Procedures for Acne** (past and present use):

| Medication | Dates used | Helped? Y or N | Medication | Dates used | Helped? Y or N |
|---|---|---|---|---|---|
| Accutane/isotretinoin<br><br>Aldactone/Spironolactone | | | Tazorac/Avage Gel<br>Tazorac/Avage Cream | | |
| Oral Tetracycline:<br>Oral Doxycycline<br>Oral Minocycline<br>Oral Tetracycline | | | Atralin/Avita/Retin-A/Tretinoin GEL<br><br>Avita/Retin-A/Tretinoin CREAM | | |
| Topical Erythromycin<br>Topical Clindamycin<br>Sodium Sulfacetamide<br>Aczone (Dapsone) | | | Ziana (Tretinoin +Clindamycin) | | |
| Benzoyl Peroxide (BPO)<br><br>Benzamycin (BPO + Erythromycin | | | Differin<br><br>Epiduo (Differin + BPO | | |
| BenzaClin/Duac/Acanya (BPO + Clindamycin) | | | Sulfur | | |
| Birth Control Pills for acne (Ortho-Tricyclen/Yaz) | | | Finacea/Azelex/ Metrogel/Mirvaso | | |
| Chemical Peel | | | Cortisone Injections (targets inflammation) | | |
| Blue Light LED Therapy (targets bacteria) | | | Smooth Beam Laser (targets oil glands) | | |

**Products used currently**

**Write brand and name, then return a separate document of full ingredient lists (or website links to full ingredient lists) for each of your products from the following:**
www.dermstore.com
www.drugstore.com
www.paulaschoice.com
www.cosdna.com

Cleanser_____
Toner_____
Serum_____
Moisturizer_____
Sunscreen_____
Mask_____
Liquid Foundation_____
Powder_____
Concealer (Acne)_____
Concealer (Under Eye)_____
Blush _____
Bronzer _____
Eye Makeup Remover _____
Shampoo _____
Conditioner _____
Leave-On Hair Product _____
Toothpaste _____
Lip Gloss/Balm _____
Lip Stick _____
Vitamins _____
Protein Powder_____
Supplements_____

**Current Home Care Routine (from above list)**

| Morning | Evening | Weekly/Monthly |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | |
| _____ | _____ | |
| _____ | _____ | |

**Allergies**
Have you ever had any allergic reactions to anything you have ever put on your skin?
What were you allergic to? (Describe): _____
Circle if you are allergic to: sulfur aspirin latex benzoyl peroxide

**Important Questions About Your Acne:**
At what age did your acne start? _____
At what age did your mother/father/family member stop breaking out? _____
Have you been diagnosed with rosacea? Y or N By whom? _____

What are your top areas of concern? (Circle All That Apply) BACK SHOULDERS CHEST
BACK OF NECK FOREHEAD HAIRLINE CHEEKS CHIN NOSE JAWLINE FRONT OF NECK

**Important Questions About Your Lifestyle:**
Do you smoke cigarettes? Y or N _____ per day/week
Do you use fabric softener or dryer sheets? _____ If yes, which brand: _____
Do you pick at your skin? _____ If yes, mindlessly or on purpose? _____
Do you have any picking tools? (Describe) _____
Are you on birth control? Which brand? _____
Do you play a musical instrument or sport? List: _____

**Important Questions About Your Eating Habits:**
Do you regularly eat or drink?: (Circle All That Apply)
kelp seaweed sushi rolls peanut butter cow's milk/yogurt
iodized salt cheese sports drinks fast food that uses peanut oil

**What else have you done for your skin?**
Circle if Yes
Chemical Peel Microdermabrasion Waxing (where on body?) _____

**Medical History:**
(Circle any condition you may have had in the past two years):
Eczema/Psoriasis HIV/AIDS Hepatitis
Thyroid Problems PCOS Staph Infection Cold Sores

**Prescribed and Over-the-Counter Medications OTHER Than for Acne (present use):**
Progesterone Steroids Thyroid Medication
Antidepressants Adderall/Concerta (ADD) Other (list): _____

**Recreational drugs:** Circle If Yes marijuana cocaine stimulants alcohol _____ per week

**Additional Information:**
What kind of work do you do? _____
Dermatologist's name and dates of care:_____
How did you hear about us? _____
*Is there anything else that we should be aware of before we start working together?
_____