Dermatology Associates of the South Bay
Amber Kyle, M.D. – Krishna Patel, PA-C

Acne Visit Form

NAME: _____ DATE: _____

D.O.B.: _____

How old are you? _____

Age break outs began? _____

Where are the breakouts? _____

Previous treatments? _____

What makes it worse or better? _____

Would you consider taking pills to treat this condition? _____

Would you be willing to apply creams 2 or more times every day to treat this condition? _____

Do you have a family history of difficult acne? _____

Do you participate in sports? _____

Females:

Do your break outs worsen around your menstrual cycle? _____

Are your menstrual cycles regular? _____

What type of make-up do you wear? _____