

Accutane Patient History

Today's Date: ____/____/____

Patient: _____ Date of Birth: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list below:

1. _____

2. _____

Have you ever had dental anesthesia (Novocaine)? YES NO Any bad reaction? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Check all that apply)

Cardiovascular

- Heart palpitations
- Stroke
- Tachycardia
- Vascular Thrombotic Disease

Endocrine/Metabolic

- Abnormal blood sugar
- Diabetes
- Hepatitis
- Hypertriglyceridemia
- Pancreatitis
- Suffer from obesity

Gastrointestinal

- Bleeding of the gums
- Colitis
- Esophagitis/esophageal ulcer
- Inflammatory bowel disease

Hematologic

- Agranulocytosis
- Anemia
- Neutropenia
- Thrombocytopenia

Musculoskeletal

- Arthralgia
- Arthritis
- Back pain
- Myalgia
- Tendonitis
- Other bone abnormalities

Neurological

- Chronic dizziness
- Chronic drowsiness
- Chronic headaches
- Insomnia
- Seizures
- Stroke
- Syncope
- Chronic weakness

Psychiatric

- Aggressive behavior
- Chronic depression
- Emotional instability
- Mood swings
- Psychosis
- Suicide thoughts/attempts

Reproductive

- Abnormal menses
- Tubal ligation
- Hysterectomy

Special Senses

- Hearing impairment
- Tinnitus
- Decreased night vision
- Cataracts
- Conjunctivitis
- Chronic dry eyes
- Chronic eyelid inflammation
- Keratitis
- Optic Neuritis

Continued on next page

Accutane Patient History (continued)

Patient: _____ Date of Birth: ____/____/____

Skin:

Has anyone else in your family had acne? No Yes

List family members _____

What previous treatments have you had for acne in the past? (Check all that apply)

- Topical Over-the-Counter preparations
What were they? _____
- Prescription topical medications – creams, soaps, cleansers
What were they? 1. _____
2. _____
3. _____
- Oral medications
What were they? 1. _____
2. _____
3. _____
- Intralesional injections
- Acne surgery
- Cryotherapy
- Laser treatments
- Photodynamic treatments
- Other _____

Do you develop skin rashes in reaction to Medications Food Environment
 Bandages Topical Neosporin
 Other _____

Social History:

Do you drink alcohol? YES NO If YES _____ drinks per day

Do you use IV drugs? YES NO If YES, what? _____
How often? _____

Do you smoke? YES NO If YES, how much: _____

Have you had or have you been exposed to HIV (AIDS)? YES NO

Please answer the following questions:

(Women) Are you pregnant? YES NO Due Date: ____/____/____

What is your occupation? _____

Hobbies? _____

Completed by:

| | | | | |
|--------------------------------------|----------------------|----------------|----------------|-------|
| <input type="checkbox"/> Patient | _____ | ____/____/____ | ____/____/____ | _____ |
| | Signed by Patient | Date | Updated | Init |
| <input type="checkbox"/> Med. Assist | _____ | ____/____/____ | ____/____/____ | _____ |
| | Initials Reviewed by | Date | Updated | Init |

Accutane Visit

Today's Date: ____/____/____

| |
|------------|
| Allergies: |
|------------|

| |
|------------------------|
| Current Medication(s): |
|------------------------|

Patient: _____ Date of Birth: ____/____/____

CHIEF COMPLAINT Acne Type: _____

HISTORY OF PRESENT ILLNESS

1. Location: _____
2. Duration: _____
3. Signs/Symptoms: _____
4. Mod. Factors: _____
5. Severity: _____
6. Quality: _____
7. Context: _____
8. Timing: _____

REVIEW OF SYSTEMS

Reproductive

Last date of menstruation ____/____/____

- Amenorrhea
- Irregular menstrual
- Regular menstrual cycles
- Other _____

General

- Allergic reactions
- Appetite/weight changes
- Difficulty moving
- Edema
- Fainting
- Fatigue
- Other _____

Psychiatric

- Depression
- Mood swings
- Aggressive behavior
- Suicidal ideation

Neurological

- Dizziness
- Headache
- Insomnia
- Other _____

Skin

- Alopecia/hair loss
- Bruising
- Dry mouth, nose, skin (circle all that apply)
- Jaundice
- Sunburn susceptibility
- Other _____

Gastrointestinal

- Inflammation of gums
- Heartburn
- Nausea
- Stomach pain
- Difficulty swallowing
- Vomiting
- Other _____

Miscellaneous

- Changes in urine color/frequency
- Diarrhea
- Hearing problems/ringing in the ears
- Rectal bleeding
- Swelling of the legs
- Vision or eye problems
 - decreased night vision
 - dry eyes
 - eyelid inflammation
 - visual disturbances
- Other _____

HISTORY - CONTRACEPTION

- Not sexually active
- BCP Name: _____
Dosage: _____
- Condoms
- Tubal Ligation
- Hysterectomy
- Abstinence
- Other _____

Accutane Visit (continued)

EXAMINATION: Patient: _____ Date of Birth: ____/____/____

Constitutional: _____

Weight: _____ BP: ____/____ Respirations: _____

| Location | Cysts | <5mm/d | >5mm/d | Pustules | Comedones | Erythema | Infection |
|--|-------|--------|--------|----------|-----------|----------|-----------|
| <input type="checkbox"/> Scalp/Hair | | | | | | | |
| <input type="checkbox"/> Head/face | | | | | | | |
| <input type="checkbox"/> Conj./Eyelids | | | | | | | |
| <input type="checkbox"/> Neck | | | | | | | |
| <input type="checkbox"/> Lips/Gums | | | | | | | |
| <input type="checkbox"/> Chest/Breast | | | | | | | |
| <input type="checkbox"/> Back | | | | | | | |
| <input type="checkbox"/> Rt. ↑ Extremity | | | | | | | |
| <input type="checkbox"/> Lt. ↑ Extremity | | | | | | | |
| <input type="checkbox"/> Rt. ↓ Extremity | | | | | | | |
| <input type="checkbox"/> Lt. ↓ Extremity | | | | | | | |
| <input type="checkbox"/> Nails | | | | | | | |
| <input type="checkbox"/> Oral Mucosa/Tong. | | | | | | | |
| <input type="checkbox"/> Peripheral Vascular | | | | | | | |
| <input type="checkbox"/> Other | | | | | | | |

MEDICAL DECISION MAKING:

DX: 1. _____
 2. _____
 3. _____
 4. _____

- Patient Counseling _____ minutes
 - Birth control
 - Importance of compliance
 - Lab testing required
 - No vitamin supplements
 - No blood donating
 - No breast feeding
 - No cosmetic procedures
 - No waxing
 - Minimize UVL exposure
 - BCP must contain estrogen
 - No herbal products
 - Avoid high impact sports
- Pamphlet given
- iPledge info given
- iPledge registration completed
- Lab work ordered
 - Pregnancy test #1 Initial in-house (urine) (serum)
 - Pregnancy test #1 Outside lab (urine) (serum)
 - Pregnancy test #2(urine) (serum)
 - Name of CLIA certified lab _____
 - Triglycerides
 - Lipids
 - Other _____

Notes:

PRESCRIPTIONS: 1. _____ 3. _____
 2. _____ 4. _____

COMPLETED BY: _____ /____/____
 Signature Date