

COLORADO DERMATOLOGY SPECIALISTS

Greenwood Village:
7000 East Belleview Ave Suite 209
Greenwood Village, CO 80111
303-850-9715

Denver:
1960 N. Ogden St Suite 555
Denver, CO 80218
303-831-0400

ISOTRETINOIN QUESTIONNAIRE

Name: _____

Date of Birth: _____

All Patients: Have you or a family member noticed any of the following signs, symptoms, or behaviors?

1. Feeling sad or crying spells?	Yes	No
2. Loss of interest in activities once enjoyed?	Yes	No
3. Sleep too much or have trouble sleeping?	Yes	No
4. Become increasingly irritable, angry or aggressive than usual?	Yes	No
5. Change in appetite or body weight?	Yes	No
6. Have trouble concentrating?	Yes	No
7. Withdrawal from friends/family?	Yes	No
8. Lethargic/loss of energy?	Yes	No
9. Have feelings of worthlessness or guilt?	Yes	No
10. Suicidal thoughts?	Yes	No
11. Acting on dangerous impulses?	Yes	No
12. Seeing or hearing things that are not real?	Yes	No
13. Alcohol or substance abuse?	Yes	No
14. Experiencing chronic pain?	Yes	No
15. Real or perceived disfigurement?	Yes	No
16. FEMALE PATIENTS OF CHILDBEARING POTENTIAL: Are you continuing agreed upon methods of pregnancy prevention? Please list methods of pregnancy and prevention: _____ & _____ The signature(s) below confirm that I (we) understand the importance of pregnancy prevention and that minimal exposure of Isotretinoin may result in severe birth defects.	Yes	No

Patient Signature

Guardian if patient is a minor

Physician Signature

Date

ISOTRETINOIN QUESTIONNAIRE

Name: _____

Date of Birth: _____

1. Self-rating of acne improvement, 1 to 10, 10 being excellent: _____		
2. Any new or change in medication, supplements, and/or herbs?	Yes	No
3. Bad headache?	Yes	No
4. Blurred vision?	Yes	No
5. Dizziness?	Yes	No
6. Nausea or vomiting?	Yes	No
7. Seizures?	Yes	No
8. Stroke?	Yes	No
9. Severe stomach, bowel, or chest pain?	Yes	No
10. Trouble or painful swallowing?	Yes	No
11. New or worsening heartburn?	Yes	No
12. Diarrhea?	Yes	No
13. Rectal bleeding?	Yes	No
14. Yellowing of skin or eyes?	Yes	No
15. Dark urine?	Yes	No
16. Back pain?	Yes	No
17. Joint pain?	Yes	No
18. Broken bones?	Yes	No
19. Muscle weakness?	Yes	No
20. Hearing problems (ringing or hearing loss)?	Yes	No
21. Vision problems (difficulty seeing at night)?	Yes	No
22. Thirsty or urinate frequently?	Yes	No
23. Difficulty breathing, faint, or feeling of weakness?	Yes	No
24. Allergic reactions (hives, swollen face or mouth, trouble breathing)?	Yes	No

Patient Signature

Guardian if patient is a minor

Physician Signature

Date