COLORADO DERMATOLOGY SPECIALISTS

South Denver:
3540 S. Poplar St, Suite 300
Denver, CO 80237
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**