

ACNE QUESTIONNAIRE

Please Include Any Chart Notes

PRESCRIBER INFORMATION				
First Name: Test	Last Name: Doctor	NPI: 123456789		
Address: 123 Doc Rd	City: Doctorville	State: FL	Zip: 33618	
PATIENT INFORMATION				
First Name: Test	Last Name: Patient	DOB: 01/01/1901		
Address: 123 Test Rd	City: Tampa	State: FL	Zip: 33618	
CLINICAL INFORMATION				
What is the patient's diagnosis?				
<input type="checkbox"/> Acne vulgaris <input type="checkbox"/> Other				
Have topicals treatment been tried and failed?				
<input type="checkbox"/> Adapalene <input type="checkbox"/> Azelaic acid <input type="checkbox"/> Benzoyl Peroxide <input type="checkbox"/> Clindamycin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Sulfacetamide <input type="checkbox"/> Tretinoin <input type="checkbox"/> Tazarotene				
Have oral treatments been tried and failed?				
<input type="checkbox"/> Doxycycline <input type="checkbox"/> Erythromycin <input type="checkbox"/> Isotretinoin <input type="checkbox"/> Minocycline <input type="checkbox"/> Tetracycline <input type="checkbox"/> Not a candidate				
In the prescriber's opinion, is Adapalene Gel 0.3% the best treatment option for the patient?				
<input type="checkbox"/> The alternatives would not be as effective for treating the patient's condition.				
<input type="checkbox"/> The alternatives would likely have adverse effects.				
<input type="checkbox"/> Stable on current medication and changing to an alternative would likely cause adverse effects.				
<input type="checkbox"/> Other				
Notes:				
All information is true and accurate to the best of my knowledge.				
*Authorized Signature: _____		Title: _____		
*Please sign to validate.				