Dermatology and Skin Cancer Institute

Accutane Review of Systems (Rev 04/2013)

Patient Name: _____ **Date:** _____

Accutane / Isotretinoin Patients: Are you currently experiencing any of the following? (please check yes or no for the following)

Symptom	Yes	No
Dry Lips		
Dry or Bloodshot Eyes		
Dry Skin		
Muscle ache/pains/weakness		
Nosebleeds		
Headaches		
Mood Swings		
Depression		
Suicidal thoughts		
Are you under the care of a psychiatrist/psychologist/therapist?		
Nail infections		
Night vision difficulty		
Sun sensitivity		
Abdominal (stomach) pain		
Nausea or vomiting		
Blood in stool		

Other Symptoms or Issues:

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