# Accutane Patient Checklist

Patient Name:

Date:

IPledge #:

Weight:

Target Dose:

Cumulative Dose:

2 Forms of Birth Control:

LMP(female patients):

| Is the patient experiencing any of the following? | Yes/No (if yes, specify) |
|---|---|
| **Bad Headaches** | |
| **Blurred Vision** | |
| **Dizziness** | |
| **Nausea or Vomiting** | |
| **Seizures** | |
| **Abdominal Pain** | |
| **Dryness of Lips** | |
| **Dryness of Eyes** | |
| **Dryness of Skin** | |
| **Joint Pain** | |
| **Nose Bleeds** | |
| **Mood Swings** | |
| **Depression** | |
| **Suicidal Thoughts** | |
| **Diarrhea** | |
| **Rectal Bleeding** | |