



COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____ Date: _____

Dear Patients: Our goal is to respond to all our patients needs and to provide the highest quality care. In order to provide the information and services you desire on the health and appearance of your skin, we invite you to complete the following questionnaire.

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Line around my eyes | <input type="checkbox"/> Thin lips | <input type="checkbox"/> Frown on corner of mouth | <input type="checkbox"/> Dimpled chin |
| <input type="checkbox"/> Lines between my eyes (angry look) | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Brown spots on face | <input type="checkbox"/> Gummy smile |
| <input type="checkbox"/> Lines on forehead | <input type="checkbox"/> Oily skin | <input type="checkbox"/> Red blotchy skin | <input type="checkbox"/> Sunk in eyes |
| <input type="checkbox"/> Lines under eyes | <input type="checkbox"/> Looking tired | <input type="checkbox"/> Excess skin above eyes | |
| <input type="checkbox"/> Puffy eyes | <input type="checkbox"/> Crease nose to corner of mouth | <input type="checkbox"/> Thin face, no cheeks | |

Health issues and procedures or product of interest to you (please check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Botox® Cosmetic (Botulinum Toxin Type A) | <input type="checkbox"/> Uneven Skin Ton | <input type="checkbox"/> Fillers (Restylane®, Collagen, etc.) |
| <input type="checkbox"/> Juvéderm™ | <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Microdermabrasion |
| <input type="checkbox"/> Sculptra® | <input type="checkbox"/> Skin Tightening | <input type="checkbox"/> Skin Care Products |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Complexion Blending | <input type="checkbox"/> Skin Care Advice |
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Earlobe Repair | <input type="checkbox"/> Vitality Peel |
| <input type="checkbox"/> Other, Please Specify: _____ | | <input type="checkbox"/> Consultation with the Aesthetician |

PLEASE ANSWER THE FOLLOWING QUESTIONS ON A SCALE OF 1 TO 5 BY CIRCLING THE APPROPRIATE NUMBER:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age:

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

HOW DID YOU HEAR ABOUT US?

My Physician: (Full Name) _____

My Insurance Company Provider: (Name) _____

Yellow Pages: (Specify Advertisement) _____

A Friend Or Family Member: (Name) _____

Another person not listed above: (Name) _____

Please provide the name and address of the person who referred you so we can thanks them.

Internet:

A seminar where I saw the doctor. The event took place (date): _____

(Location) _____