COSMETIC INTEREST QUESTIONNAIRE

Patient Name:	Date:

General appearance or products of interest to you (please check all that apply).

❑ Skin care advice	❑ Facial veins	❑ Neck elasticity
❑ Skin care products	❑ Facial redness	❑ Lower face elasticity
❑ BOTOX® Cosmetic	❑ Leg veins	❑ Abdominal elasticity
❑ Facial fine lines	❑ Liver spots/age spots	❑ Make-up consultation
❑ Facial wrinkles	❑ Birthmark	❑ Permanent Make-up
❑ Facial folds	❑ Longer eyelashes	❑ Hair reduction
❑ Thin lips	❑ Drooping eyelids/ Dark circles	❑ Tattoo removal
❑ Blotchy skin	❑ Acne	❑ Weight loss
❑ Pore size and texture	❑ Acne scaring	

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:*
❑ The yellow pages	*Specify Ad:*
❑ A friend or family member	*Name:*
❑ Internet	
❑ The Physician/Practice website	
❑ Seminar	*Date/location:*
❑ Other	

Are you interested in meeting with one of our professional cosmetic consultants in order to create a Personal Treatment Plan designed to meet your cosmetic needs?

❑ YES ❑ No thanks

❑ Approval to contact you.	*Best phone number to reach you:*
❑ Approval to send you information on products and services (including special offers)	*Email address:*

Patient Signature: ***Date:***

Comments:

PATIENT INFORMATION Date:________________

Name:____

Address:____

City:_______________________State:___________________Zip:_________________

Home Phone:________________________ Work Phone:_________________________

Cell Phone:___________________________Email:______________________________

Employer:___________________________ Occupation:_________________________

Birthdate:____/____/____ Age:_____ Sex: Female_____ Male_______

Emergency Contact Name:____

Phone:__________________________ Relationship:____________________________

Did a friend or relative refer you to us? Name:__________________________________

May we thank them for the referral? Yes____ No____

HISTORY:

Are you allergic/reactive to any medications, products, or skin care ingredients?

If so, please list:____

Do you currently have, or have a history of any medical conditions (diabetes, thyroid disorder, hormone imbalance, high blood pressure, hepatitis, skin cancer, heart problems, vitiligo, coagulopathies, wound infections, keloids, or hypertropic scarring?

If so, please list:____

Are you pregnant or nursing? Yes______ No_______

Do you have a history of Herpes? Yes____ No_______
If so, when was your last outbreak?____

Have you had Gold Therapy, for Rheumatoid Arthritis? Yes____ No_____
If so,
when?____

Have you had a recent surgery? Yes____ No____
If so when?____

List any medications, vitamins, or other nutritional supplements/herbs that you take on a regular or occasional basis (including aspirin):___________________________________

Have you recently used any special creams or medications to treat a skin condition? If so, please list:____

Do you experience big mood swings in your mood or suffer from depression or anxiety? Yes____ No____

Do you have permanent makeup or tattoos? Yes____ No____ If so, what areas? ____

Do you smoke? Y/N
Exercise regularly? Y/N
Wear Contacts? Y/N
Do you take diet pills? Y/N
Do you drink caffeinated beverages? Y/N – If yes how much daily?_________________
Do you regularly use a sunscreen on your skin? Y/N – If yes, usual SPF______________
How many alcoholic beverages do you consume ?__daily__weekly__monthly__ rarely
Have a pacemaker or defibrillator? Y/N
Have implants or metal implants? Y/N
Do you take diuretics or laxatives? Y/N
How much water do you drink daily?____
Do you have ___oily___dry___or___acne-prone skin?

Skin type, or when exposed to the sun WITHOUT PROTECTION for approx. one hour:
___I Always burns, never tans
___II Always burns, sometimes tans
___III Sometimes burns, sometimes tans
___IV Always tans
___ V __Hispanic__Mediterranean__Middle Eastern
___ VI Black
What is your national origin? __________________________

Do you blush easily when nervous? Y/N Do you often experience facial redness/flushing? Y/N

Do you use self-tanning lotions? Y/N Most recent use:_____________________________

Do you use a tanning bed? Y/N Most recent use:_____________________________

When was your last significant exposure to the sun with little or no sunscreen?_________

Are you planning a holiday in the sun? Y/N If so when?__________________________

What methods do you or have you used for hair removal? __shaving__electrolysis __plucking__waxing__bleaching__creams(Nair)__

Prior treatment with Intense Pulse Light? Y/N If so, when? ____________________

Have you had a chemical peel? Y/N? What type?____________Most recent?_________

Have you had a microdermabrasion? Y/N Most recent?___________________________

Previous Botox? Y/N Most recent ? _____________Area treated?__________________

Previous Collagen? Y/N? Most recent? ___________Area treated?__________________

Do you experience skin breakouts? Y/N? Can you relate it to any cause?______________

Do you ever experience these conditions on your skin?__oily _tightness__dryness
What type of skin care products are you currently using?________________________
bar soap__cleanser__toner__masque__moisturizer__scrub/peel__other_____________

Do you have any other issues or questions that you would like us to address today? Please specify:____

What are your expectations from your treatment here?__________________-
____
____
_

____
Can we take your photos for your files? ____Yes ___No

Thank you…..This information is completely confidential, and will be used only to help us give you the best care possible.