



Cosmetic Interest Questionnaire

Patient Name: _____

DOB : _____

Cosmetic concerns or products of interest to you (please check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Skin care advice | <input type="checkbox"/> Facial wrinkles |
| <input type="checkbox"/> Facial fine lines | <input type="checkbox"/> Sun damaged skin |
| <input type="checkbox"/> Enlarged pores | <input type="checkbox"/> Skin discoloration |
| <input type="checkbox"/> Skin texture | <input type="checkbox"/> Skin laxity |
| <input type="checkbox"/> Sun spots/Age spots | <input type="checkbox"/> Unwanted tattoos |
| <input type="checkbox"/> Unwanted hair | <input type="checkbox"/> Facial redness |
| <input type="checkbox"/> Facial veins/broken capillaries | <input type="checkbox"/> Rosacea |
| <input type="checkbox"/> Birthmarks | <input type="checkbox"/> BOTOX® Cosmetic |
| <input type="checkbox"/> Latisse | <input type="checkbox"/> Dysport |
| <input type="checkbox"/> Dermal Fillers (Restylane/Perlane, Juvederm) | |

Are you interested in meeting with our professional cosmetic consultant in order to create a personal treatment plan designed to meet your cosmetic needs?

- YES No thanks

May we contact you with regard to special promotions and new cosmetic products or services?

YES email address: _____

telephone #: _____

- No thanks

Patient Signature:

Date: