



Cosmetic Interest Questionnaire

Patient's Name: _____ Today's Date: _____

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

- | | |
|--|--|
| <input type="checkbox"/> BOTOX® Cosmetic | <input type="checkbox"/> Skin Care Advice |
| <input type="checkbox"/> Skin Tightening | <input type="checkbox"/> Skin Care Products |
| <input type="checkbox"/> Cellulite reduction | <input type="checkbox"/> Non-invasive Body Contouring |
| <input type="checkbox"/> Non-invasive treatment for improvement of neck area | <input type="checkbox"/> Stretch mark reduction |
| <input type="checkbox"/> Skin Rejuvenation | <input type="checkbox"/> Liver Spots/Age Spots |
| <input type="checkbox"/> Retin-A or Retinol | <input type="checkbox"/> Sunscreen Advice |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Filler lines around mouth |
| <input type="checkbox"/> Acne or acne scars | <input type="checkbox"/> Facials and Eye Treatments |
| <input type="checkbox"/> Chemical Peels | <input type="checkbox"/> Laser Hair Removal |
| <input type="checkbox"/> Laser Resurfacing | <input type="checkbox"/> Spider Vein Treatments |
| <input type="checkbox"/> Laser Pigment Removal | <input type="checkbox"/> Removing Facial Veins |
| <input type="checkbox"/> Photorejuvenation | <input type="checkbox"/> Consultation with the Esthetician |
| <input type="checkbox"/> Other, please specify: _____ | |

Address: _____ City/State/Zip code _____

Phone number: _____ Email address: _____

How did you hear about us? _____

Please list any prescription or non-prescription medication you are currently taking. _____

Please list any drug or food allergies you may have. _____

Please list any cosmetic procedure you have previously had. (ex: facial, chemical peel, botox, lasers, plastic surgery, etc.)

Please list the skin care products you are currently using on your face. _____

Please explain what concerns you have about your skin and what your skin care goals might be.

Thank you!