

Cosmetic Interest Questionnaire

For many people, changes in physical appearance as we age can have a significant impact on self-confidence and even quality of life. Fortunately, today there are many options available to dramatically enhance and improve one's appearance, and reverse signs of aging.

Contact Information

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ Mobile phone: _____

Work phone: _____

E-mail address: _____

Please indicate your preferred method of contact: _____

By letting us know your concerns and preferences, we can help you decide which treatments will offer you the best results.

For the following statements, please circle the number that best reflects your opinion, with 1 as agreeing the least and 5 as agreeing the most.

1. If effective, non-surgical options were available to successfully correct my lines and wrinkles, I would be interested.

1 2 3 4 5

2. I would prefer correcting my wrinkles and lines with a product that does not contain animal-derived ingredients.

1 2 3 4 5

3. What cosmetic procedures, if any, have you had in the past?

4. If you have previously had any cosmetic procedures, were you pleased with the outcome?

Yes No

If no, in what way were you dissatisfied?

5. Sometimes the best results can be achieved through different products or procedures by using multiple products or procedures. Please let me/us know which of the following would interest you. Check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Dermal fillers such as <i>Restylane</i> [®] | <input type="checkbox"/> Skin-care advice |
| <input type="checkbox"/> AHA and glycolic peels | <input type="checkbox"/> Skin-care products |
| <input type="checkbox"/> Skin rejuvenation | <input type="checkbox"/> Birthmark correction |
| <input type="checkbox"/> Topical wrinkle treatments such as <i>RENOVA</i> [®] | <input type="checkbox"/> Liver spot/age spot correction |
| <input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Sunscreen advice |
| <input type="checkbox"/> BOTOX [®] Cosmetic | <input type="checkbox"/> Leg vein correction or removal |
| <input type="checkbox"/> Acne treatment | <input type="checkbox"/> Facials and hair treatments |
| <input type="checkbox"/> Chemical peels | <input type="checkbox"/> Hair removal |
| <input type="checkbox"/> Laser resurfacing | <input type="checkbox"/> Facial vein removal or correction |
| <input type="checkbox"/> Laser treatments | <input type="checkbox"/> Other (please specify): _____
_____ |

6. If our office hosted an event to inform patients about cosmetic procedures, would you be interested in attending?

- Yes No

If yes, may we contact you about these events?

- Yes No Signature _____

7. How did you hear about our practice?

- | | |
|--|--|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Friend or family member | <input type="checkbox"/> Phone book |
| <input type="checkbox"/> Seminar | <input type="checkbox"/> Advertisement or article (please specify):
_____ |
| <input type="checkbox"/> Insurance company | <input type="checkbox"/> Other (please specify):
_____ |

8. If you were referred by one of our patients, please let us know the name so that we may thank him or her. _____

Thank You.

With respect to signs of aging, please highlight those areas of the face that bother or trouble you. In the box provided, please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome).

