Cosmetic Interest Questionnaire

NAME _____

WHAT BRINGS YOU TO THE OFFICE TODAY?

_____

DO YOU HAVE OTHER AREAS OF CONCERN?

(PLEASE CHECK ALL THAT APPLY)

- [ ] FROWN LINESON BROW, FOREHEAD, EYES, OR NOSE
- [ ] HOLLOWSAROUND THE NOSE AND MOUTH
- [ ] SKIN PIGMENT, SUN SPOTS
- [ ] ACNE SCARS
- [ ] FINE LINES,WRINKLES, SAGGING SKIN
- [ ] ROUGH SKIN TEXTURE
- [ ] DARK CIRCLES UNDER EYES
- [ ] CELLULITE
- [ ] BIRTHMARKS

ARE YOU INTERESTED IN LEARNING MORE ABOUT THE FOLLOWING?

(PLEASE CHECK ALL THAT APPLY)

- [ ] BOTOX® COSMETIC
- [ ] SKIN CARE PRODUCTS
- [ ] SPIDER VEIN TREATMENTS
- [ ] FACIALS AND EYE TREATMENTS
- [ ] JUVÉDERM™ INJECTABLES
- [ ] SKIN REJUVENATION

HOW DID YOU HEAR ABOUT US?

- [ ] FRIEND OR FAMILY MEMBER
- [ ] PHYSICIAN OR OTHER HEALTHCARE PROVIDER
- [ ] ADD OR ARTICLE
- [ ] WEB SEARCH

_____

_____

_____

_____

Medical Form

NAME _____ DATE OF BIRTH ☐☐ ☐☐ ☐☐

ADDRESS _____

PHONE _____ DATE _____

MOBILE _____ TIME _____

EMERGENCY CONTACT _____

HAVE A HISTORY OF : CHECK ALL THAT APPLY

- LIVER DISEASE ☐
- FAINTING ☐
- DIABETES ☐
- CANCER ☐
- HIGH BLOOD PRESSURE ☐
- THYROID PROBLEMS ☐
- KELOID SCARRING ☐
- OTHER ☐

MEDICATIONS

_____

SURGERIES

_____