COSMETIC INTEREST QUESTIONNAIRE

Patient Name:	Date:

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

❑ Skin care advice	❑ Facial veins	❑ _____
❑ Skin care products	❑ Facial redness	❑ _____
❑ BOTOX® Cosmetic	❑ Sun spots/age spots	
❑ Facial fine lines	❑ Birthmark	
❑ Facial wrinkles	❑ Loose skin	
❑ Facial folds	❑ Nose	
❑ Thin lips	❑ Unwanted hair	
❑ Blotchy skin	❑ Dense eyelashes	

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:***

For Office Use Only

Physician (provider) name:		
Follow-up	*Date*	*Completed by (name)*
❑ Initial Inquiry/Information Mailed		
❑ Follow-up call		
❑ Seminar participation		
❑ Free consultation		
❑ Procedure scheduled		
❑ Procedure completed		

Comments: