

Cosmetic Interest Questionnaire

Please complete this questionnaire to help us create your personalized treatment plan.

If you are not interested in cosmetic procedures, you do not need to complete this form. Thank you!

Name: _____ Date: _____

What is the main reason you are here for this consultation?

What cosmetic treatments, if any, have you had in the past?

Of the treatments you've had in the past, were there any that you were dissatisfied with?

Please list any concerns you have about cosmetic treatments.

Do you feel like you look older than you really are?

☐ Yes ☐ No

Do you have any concerns about wrinkles or fine lines?

☐ Yes ☐ No

Do you have any concerns about sun damage, age spots or redness?

☐ Yes ☐ No

Do you have any concerns about the texture of your skin?

☐ Yes ☐ No

Please let us know which of the following interest you.

Check all that apply:

- ☐ Wrinkle relaxer (e.g. Botox, Dysport)
- ☐ Dermal/Wrinkle Filler
- ☐ Laser Rejuvenation Treatments
- ☐ Skin Tightening
- ☐ Fat Reduction
- ☐ Scar Removal
- ☐ Laser Hair Removal
- ☐ Unsightly Veins Removal
- ☐ Skin Care Products
- ☐ Sun Protection
- ☐ Other:

Please circle the areas of the face that bother you and identify your top three (3) concerns.

