

COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____

Date: _____

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

<input type="checkbox"/> Skin care advice <input type="checkbox"/> Skin care products <input type="checkbox"/> BOTOX [®] Cosmetic <input type="checkbox"/> Facial fine lines <input type="checkbox"/> Facial wrinkles <input type="checkbox"/> Facial folds <input type="checkbox"/> Thin lips <input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Facial veins <input type="checkbox"/> Facial redness <input type="checkbox"/> Liver spots/age spots <input type="checkbox"/> Birthmark <input type="checkbox"/> Tatoo removal <input type="checkbox"/> Drooping eyelids <input type="checkbox"/> Nose <input type="checkbox"/> Facial fullness	<input type="checkbox"/> Neck <input type="checkbox"/> Breast size <input type="checkbox"/> Abdominal area <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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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.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
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.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

How did you hear about us?

<input type="checkbox"/> My physician	<i>Full name:</i>
<input type="checkbox"/> My insurance company provider	<i>Name:</i>
<input type="checkbox"/> The yellow pages	<i>Specify Ad:</i>
<input type="checkbox"/> A friend or family member	<i>Name:</i>
<input type="checkbox"/> Internet	
<input type="checkbox"/> The Physician/Practice website	
<input type="checkbox"/> Seminar	<i>Date/location:</i>
<input type="checkbox"/> 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

<input type="checkbox"/> Approval to contact you.	<i>Best phone number to reach you:</i>
<input type="checkbox"/> Approval to send you information on products and services (including special offers)	<i>Email address:</i>

Patient Signature: _____

Date: _____

For Office Use Only

Physician (provider) name:		
<i>Follow-up</i>	<i>Date</i>	<i>Completed by (name)</i>
<input type="checkbox"/> Initial Inquiry/Information Mailed		
<input type="checkbox"/> Follow-up call		
<input type="checkbox"/> Seminar participation		
<input type="checkbox"/> Free consultation		
<input type="checkbox"/> Procedure scheduled		
<input type="checkbox"/> Procedure completed		

Comments: