Cosmetic Interest Questionnaire

Name_______________________________________

What brings you to the office today?____

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Do you have other areas of concern? *(please check all that apply)*

Frown lines on brow, forehead, eyes, or nose Hollows around the nose and mouth Skin pigment, sun spots Acne scars Fine lines, wrinkles, sagging skin Rough skin texture	Dark circles under eyes Breast size / shape Fat in belly, flanks, arms, legs, chest, or neck 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™ Injectable Gel Skin rejuvenation Facelift	Necklift Rhinoplasty (nose correction) Chin Augmentation/Reduction Fat Transfer Otoplasty (Ear Surgery) Contouring after Weight Loss Inverted Nipple Correction Gynecomastia (Male Breast Reduction)	Abdominoplasty (tummy tuck) Breast augment Breast lift Labiaplasty Liposuction Thigh/Arm lift Eyelid lift

Other:____

How did you hear about us?

Friend or family member____
Physician or other healthcare provider____
Ad or Article____
Web Search____
Seminar or other event (date and location)_______________________________________
Other____