FACE sarah hamilton

COSMETIC INTEREST QUESTIONNAIRE

Patient's Last Name:	First:	Middle:	Title	Date of Birth
			☐ Mr. ☐ Miss ☐ Mrs. ☐ Dr.	

Our goal is to respond to all of our patient's needs and to provide the highest quality care. In order to provide the information and services you desire on the health and appearance of your skin and body, we invite you to complete the following questionnaire.

Please check all that apply.

- ☐ Lines around eyes (crow's feet)
- ☐ Lines between eyes (angry look)
- ☐ Lines on forehead
- ☐ Lines under eyes
- ☐ Puffy eyes
- ☐ Thin lips
- ☐ Dry Skin
- ☐ Oily Skin
- ☐ Sagging brows, excess skin above eyes (looking tired)
- ☐ Frown on corner of mouth (marionette lines)
- ☐ Crease nose to corner of mouth (parenthesis lines/nasolabial folds)
- ☐ Brown spots on face
- ☐ Red, blotchy skin
- ☐ Jowls, irregular jawline, double chin
- ☐ Thin face, no cheek angles or contour
- ☐ Dimpled chin
- ☐ Sunken in eyes (tired looking)
- ☐ Acne
- ☐ Feminine concerns (vaginal dryness & rejuvenation)

Please check all of the following procedures about which you would like more information.

- ☐ Age spots / facial pigmentation problems
- ☐ Botox®, Dysport®
- ☐ Fillers (Juvederm®, Restylane®, PRP, Sculptra®)
- ☐ Excessive sweating (Hyperhidrosis)
- ☐ Medical-grade skin care
- ☐ Age spots / facial pigmentation problems
- ☐ Acne, oily skin
- ☐ Facelift (facial rejuvenation)
- ☐ Forehead / brow lift
- ☐ Neck lift / excess chin volume
- ☐ Chin or cheek augmentation or filler
- ☐ Laser hair removal
- ☐ Photo rejuvenation / rosacea treatment
- ☐ Laser facial resurfacing
- ☐ Feminine rejuvenation

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Signature of Patient (or Parent or Guardian) *Date*

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Signature of Practitioner *Date*

Copy to: Patient Chart