



akron plastic surgeons

COSMETIC INTEREST QUESTIONNAIRE

Patient Name:

Date:

What are your areas of concern?

<input type="checkbox"/> Age spots	<input type="checkbox"/> Facial wrinkles	Other _____
<input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Hips	
<input type="checkbox"/> Breasts	<input type="checkbox"/> Legs	
<input type="checkbox"/> Buttocks	<input type="checkbox"/> Neck area	
<input type="checkbox"/> Drooping/saggy eyelids	<input type="checkbox"/> Nose	
<input type="checkbox"/> Facial fine lines	<input type="checkbox"/> Skin care advice	
<input type="checkbox"/> Facial folds	<input type="checkbox"/> Thin lips	
<input type="checkbox"/> Facial redness	<input type="checkbox"/> Tummy	

Are you interested in learning more about the following?

- BOTOX® Cosmetic
- Facial chemical peels
- Juvederm (Facial Fillers)
- Microdermabrasion
- Pharmacy grade skin care products

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

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

Patient Signature:

Date:

For Office Use Only

Physician (provider) name: DSW JCP MGP

<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		

Comments: