

FACIAL & COSMETIC QUESTIONNAIRE

Your Name: _____ Date: _____

Reason for visit today: _____

We appreciate that you chose our practice for your care. Our goal is to respond to all of your 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, we invite you to complete the following questionnaire:

Please check all of the concerns you may have below:

☐	Lines around my eyes – “Crow’s Feet”	☐	Crease from nose to corner of mouth – Nasal Labial Folds
☐	Lines above nose – “The Eleven Line”	☐	Down turning on the corners of the mouth
☐	Lines on Forehead	☐	Thin Lips
☐	Lines under eyes	☐	Thin Face, Loss of volume
☐	Puffy eyes – Lower Eyelid “Bags”	☐	Red, blotchy, sensitive skin / Rosacea
☐	Heavy upper eyelid skin	☐	Oily Skin
☐	Dark Circles	☐	Acne
☐	Dimpled chin	☐	Dry Skin
☐	Facial Scars	☐	Facial Veins – Broken Blood Vessels, Capillaries
☐	Skin Lesions, Moles, Skin Tags	☐	Spider Veins on Legs
☐	Brown Spots – Hyperpigmentation, Age Spots	☐	Spider Veins on Face
☐	Cysts, skin cancers, lipomas	☐	Facial Hair

Specific procedures, treatments, or products of interest to you (Please check all that apply)

☐	BOTOX	☐	Retin A, Tretinoin, Retinol
☐	Juvederm or Restylane Fillers	☐	Non-Surgical Facials or Procedures
☐	Chemical Peels	☐	Skin Rejuvenation
☐	Microdermabrasion	☐	Consultation with the Aesthetician/Nurse
☐	Dermaplaning	☐	Acne scar or keloid treatments
☐	Skin Care Advice	☐	Spider Vein Treatments for Face and Legs – Sclerotherapy
☐	Home Skin Care Products(cleanser, toner, treatment serums, moisturizers, SPF, etc.)	☐	Other, please specify:

Thank you for taking the time to complete this survey. How would you like to be contacted about possible treatment options?

Complimentary in person
consultation In the office

Phone call with our registered
nurse or licensed aesthetician

Text or email me with
detailed information