Eastside Dermatology & Skin Care Center
Cosmetic Interest Questionnaire

Patient Name: _____ **Date:** _____

☐ BOTOX® Cosmetic ☐ Acne ☐ Removing Leg Veins

☐ Skin Care Advice ☐ Birthmarks ☐ Facials and Eye Treatments

☐ AHA and Glycolic Peels ☐ Sunscreen Advice ☐ Spider/Varicose Vein Treatments

☐ Skin Care Products ☐ Hair Removal ☐ Laser Treatments

☐ Skin Rejuvenation/Wrinkles ☐ Fillers ☐ Removing Facial Veins

☐ Liver Spots/Age Spots/Masks ☐ Chemical Peels ☐ Retin-A or Renova

☐ Micro-Dermabrasion ☐ Laser Resurfacing ☐ Scars or Stretch Marks

Longer, Fuller, Darker Eye Lashes

☐ Other: Please Specify _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When viewing my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, how concerned are you about the appearance of wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

☐ My physician (full name) _____

☐ My insurance company provider (name) _____

☐ The yellow pages

☐ A friend or family member (name) _____

☐ Internet search

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Would you like to be notified of special events and savings for Cosmetic Services and Products?

If so, how should we contact you? ☐ Email to: _____

☐ Mail to: _____

Approval to Send Information _____

Patient Signature