

Dawes Fretzin Dermatology Cosmetic Interest Questionnaire

For many people, changes in physical appearance as we age can have a significant impact on self-confidence and even quality of life. Fortunately, today there are many options available to dramatically enhance and improve one's appearance and reverse the signs of aging.

Contact Information

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ Mobile phone: _____

Work phone: _____

E-mail address: _____

Please indicate your preferred method of contact: _____

By letting us know your concerns and preferences, we can help you decide which treatments will offer you the best results.

1. If effective non-surgical options were available to successfully correct my lines and wrinkles, I would be interested. Yes or No.

2. What cosmetic procedures, if any, have you had in the past?

3. If you have previously had any cosmetic procedures, were you pleased with the outcome? Yes or No If no, in what way were you dissatisfied? _____

4. If our office hosted an event to inform patients about cosmetic procedures, would you be interested in attending? Yes or No. If yes, may we contact you about these events? Yes or No Signature: _____

5. How did you hear about our practice?

- Physician
- Friend or family member
- Seminar
- Insurance Company
- Internet
- Phone book
- Advertisement or article (please specify):

Other (please specify):

Available Products and Procedures

Combining products and/or procedures may enhance your overall benefit. Please let me/us know which of the following would interest you. Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Dermal fillers such as: <i>Restylane</i> ®, <i>Juvéderm</i> ®, <i>Radiesse</i> ®, <i>Perlane</i> ® | |
| <input type="checkbox"/> BOTOX® Cosmetic | <input type="checkbox"/> Facial vein removal |
| <input type="checkbox"/> Anti-Aging skin products & treatments | <input type="checkbox"/> Leg vein correction |
| <input type="checkbox"/> Skin-care products | <input type="checkbox"/> Skin rejuvenation/ IPL Laser |
| <input type="checkbox"/> Skin-care advice | <input type="checkbox"/> Birthmark correction |
| <input type="checkbox"/> Acne treatment | <input type="checkbox"/> Laser Hair removal |
| <input type="checkbox"/> Chemical peels | <input type="checkbox"/> Liver spot/age spot correction |
| <input type="checkbox"/> Mineral cosmetics/Eyelash growth | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Sunscreen advice | _____ |
| <input type="checkbox"/> Vibradermabrasion
(new generation of microdermabrasion) | _____ |

Anatomic Representation

With respect to signs of aging, please rate the areas of the face that concern you most. In the box provided, please rate these areas on a scale of 1 to 5 (1 being least concern, 5 being most concern).

- | | |
|---|---|
| _____ Forehead | _____ Freckles/Age spots/Pigmentation |
| _____ Crow's feet | _____ Frown lines |
| _____ Dark circles | _____ Nose-to-mouth lines |
| _____ Marionette lines/Smile lines | _____ Facial Blood vessels |
| _____ Vertical lip lines (smokers' lines) | _____ Large pores, poor skin texture & fine lines |