

COSMETIC INTEREST QUESTIONNAIRE

Dear Patient: 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, we invite you to complete the following questionnaire:

Please check all that apply:

- | | | | |
|--------------------------------------|-------------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | Wrinkle Reduction | <input type="checkbox"/> | Hyperhidrosis |
| <input type="checkbox"/> | AHA and Glycolic Peels | <input type="checkbox"/> | (excessive sweating) |
| <input type="checkbox"/> | Juvederm™ or Collagen Therapy | <input type="checkbox"/> | Skin Care Advice |
| <input type="checkbox"/> | Skin Rejuvenation | <input type="checkbox"/> | Skin Care Products |
| <input type="checkbox"/> | Skin Texture | <input type="checkbox"/> | Birthmarks |
| <input type="checkbox"/> | Micro-Dermabrasion | <input type="checkbox"/> | Liver Spots/Age Spots |
| <input type="checkbox"/> | Acne | <input type="checkbox"/> | Sunscreen Advice |
| <input type="checkbox"/> | Chemical Peels | <input type="checkbox"/> | Removing Leg Veins |
| <input type="checkbox"/> | Pore Size | <input type="checkbox"/> | Facials /EyeTreatments |
| <input type="checkbox"/> | Laser Treatments | <input type="checkbox"/> | Hair Removal |
| <input type="checkbox"/> | PREVAGE™MD | <input type="checkbox"/> | Spider Vein Treatments |
| (anti-aging/antioxidant treatments) | | <input type="checkbox"/> | Removing Facial Veins |

Other – Please Specify: _____

How did you hear about us?

My Doctor or Insurance Company Provider: _____

Ad (specify advertisement): _____

A Friend or Family Member: _____

Other: _____

I WOULD LIKE TO BE CONTACTED FOR FURTHER INFORMATION, EVENTS AND PROMOTIONS. THE BEST WAY TO CONTACT ME IS:

Telephone: _____

E-mail: _____

Mailing Address: _____

Signature: _____

Date: _____