

SOUTH END DERMATOLOGY & SKIN CARE

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 SouthEndDermatology.com

COSMETIC INTEREST QUESTIONNAIRE

Patient Name: _____ Date: _____

General appearance or products of interest to you (please check all that apply).

<input type="checkbox"/> Skin care advice	<input type="checkbox"/> Facial veins	<input type="checkbox"/> Neck
<input type="checkbox"/> Skin care products	<input type="checkbox"/> Facial redness	<input type="checkbox"/> Breast size
<input type="checkbox"/> BOTOX® Cosmetic	<input type="checkbox"/> Liver spots/age spots	<input type="checkbox"/> Abdominal area
<input type="checkbox"/> Facial fine lines	<input type="checkbox"/> Birthmark	<input type="checkbox"/> Hips
<input type="checkbox"/> Facial wrinkles	<input type="checkbox"/> Tattoo removal	<input type="checkbox"/> Legs
<input type="checkbox"/> Facial folds	<input type="checkbox"/> Drooping eyelids	<input type="checkbox"/> _____
<input type="checkbox"/> Thin lips	<input type="checkbox"/> Nose	<input type="checkbox"/> _____
<input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Facial fullness	<input type="checkbox"/> _____

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

How did you hear about us?

<input type="checkbox"/> My physician	<i>Full name:</i>
<input type="checkbox"/> My insurance company provider	<i>Name:</i>
<input type="checkbox"/> The yellow pages	<i>Specify Ad:</i>
<input type="checkbox"/> A friend or family member	<i>Name:</i>
<input type="checkbox"/> Internet	
<input type="checkbox"/> The Physician/Practice website	
<input type="checkbox"/> Seminar	<i>Date/location:</i>
<input type="checkbox"/> Other	

Are you interested in meeting with one of our professional cosmetic consultants in order to create a Personal Treatment Plan designed to meet your cosmetic needs?

YES No thanks

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

Patient Signature: _____

Date: _____

