OAKLAND HILLS
DERMATOLOGY
• General • Cosmetic & Surgical Institute •

(Patient Optional)

Cosmetic Interest Questionnaire

Name:

Address:

Telephone:

Please e-mail me information on special offers and events!

Yes_____ No_____

E-Mail Address: _____

Are you interested in a cosmetic Ladies Night Out? _____

Birth Date:

How did you hear about us? (circle one below)

Magazine	Newspaper	Billboard
Radio	Phone Book	Sign out Front
Friend	Family	Employee

Physician Referral, Who: _____

Other, Please Specify:

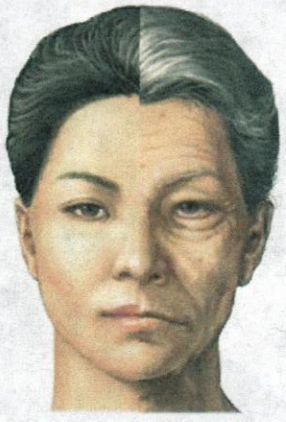
These are the areas of concern for me:

- ☐ Fine Lines and wrinkles
- ☐ Frown Lines between the brows
- ☐ Wrinkles / Lines around nose and mouth
- ☐ Age Spots / Liver Spots
- ☐ Freckles / Sun Damage
- ☐ Dark circles under eyes
- ☐ Length / Thickness of eyelashes
- ☐ Texture of skin / Pore Size
- ☐ Facial Veins
- ☐ Birthmarks
- ☐ Uneven skin tone
- ☐ Dryness
- ☐ Skin Care Products
- ☐ Skin Care Advice
- ☐ Acne

Ranking of concerns:

1.
2.
3.
4.
5.
6.
7.

Please feel free to mark areas of concern on facial diagram.



Other Questions or Comments:

When looking at 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, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned — *Somewhat Concerned* — *Very Concerned*

1 2 3 4 5

Signature:

Private and Confidential