Aesthetic Patient Self Assessment

Please complete this questionnaire to help us better understand your history, preferences, and concerns with respect to aesthetic treatments and procedures. Your responses will help us identify and recommend the most appropriate treatments and procedures for you.

Patient Name:_____Date:_____

What is your reason for your visit today?

What aesthetic treatments and procedures, if any, have you had in the past?

If you have previously had any aesthetic treatments or procedures, were you pleased with the outcome?

___ Yes ___ No If no, in what way were you dissatisfied?

Do you have any concerns about aesthetic treatments or procedures? ___ Yes ___ No
If yes, identify your concerns:

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Aesthetic Products, Treatments, and Procedures

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

☐ Skin care products ☐ Injectable treatments ☐ Facial fine lines/wrinkles ☐ Thin lips ☐ Blotchy skin ☐ Facial peels ☐ Make Up	☐ Botox/Dysport ☐ Facial veins ☐ Facial redness/Rosacea ☐ Brown spots/age spots/freckle ☐ Drooping brow ☐ Drooping eyelids ☐ Facial fullness/drooping ☐ Scar(s) ☐ Neck wrinkles	☐ Fat Bulges ☐ Under Chin Fat (Double Chin) ☐ Body Contouring ☐ Unwanted Hair ☐ Length/Fullness of Eyelashes ☐ Stretch Marks ☐ Acne ☐ Dermal Fillers

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	Website:
☐ Seminar	Date/Location:
☐ Skirt Magazine	
☐ TV	

☐ Approval to contact you	Best phone number to reach you:
☐ Approval to send you information on products and services(including special offers)	Email address:

☐ I'm not interested in any additional services provided at this time.

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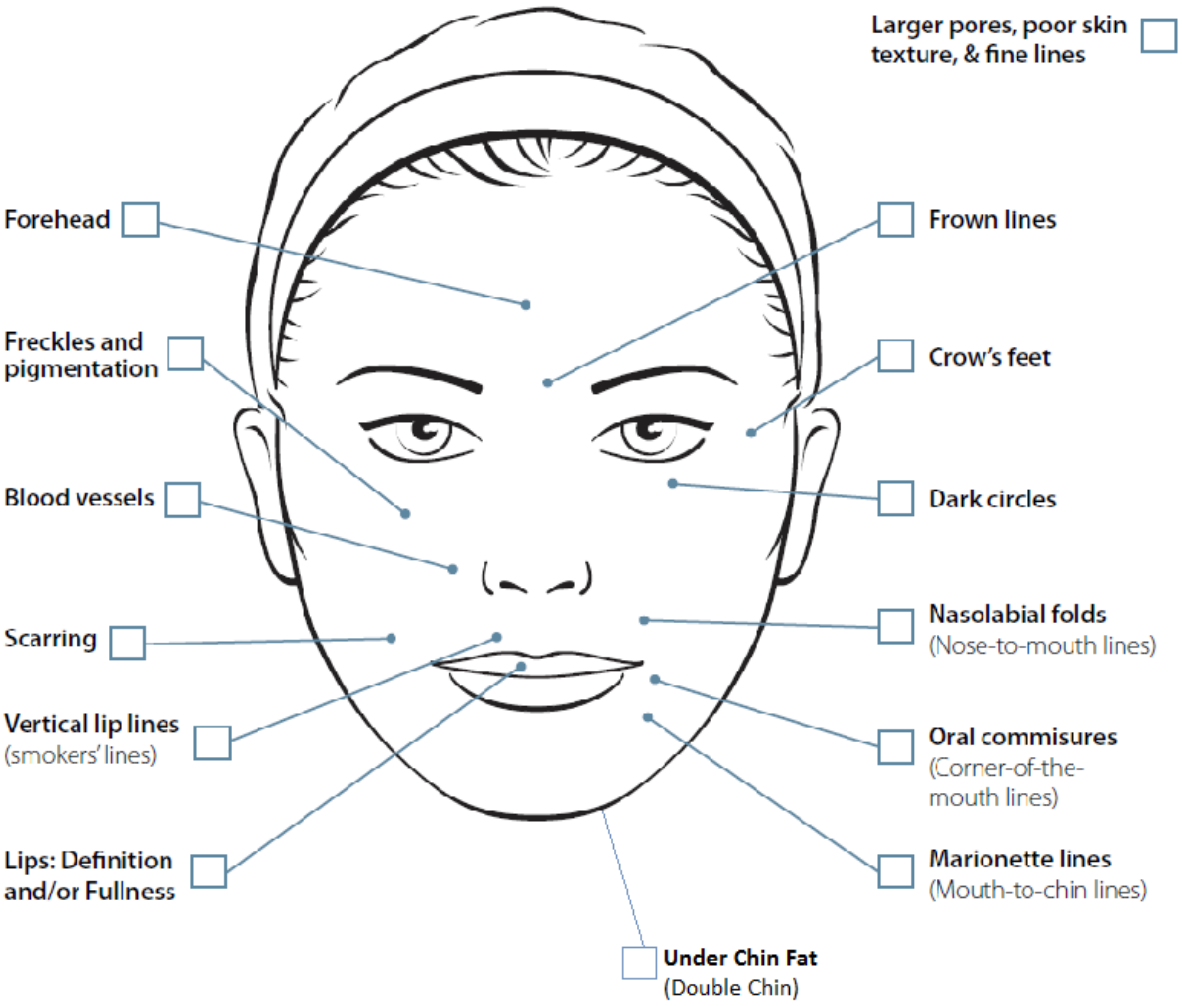
Facial Anatomic Representation

With respect to facial aesthetics, please highlight those areas of the face that bother or trouble you.

In the boxes provided, please rate these areas on a scale of 1 to 5 (1 being least bothersome, 5 being most bothersome).

Feel free to draw on the chart to identify any other facial concerns.



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Skin Typing…

		0	1	2	3	4
	What is your eye color?	Light blue or gray	Blue or green	Hazel, Light brown	Dark brown	Brownish black
	What is the natural color of your hair?	Red, Sandy red	Blonde	Dark blonde, chestnut brown	Dark brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
	To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

For office use only:

Add above for Total score:	Match your total score with the corresponding Skin Type.	Fitzpatrick Skin Type:
	0-7 8-16 17-25 26-30 Over 30	I II III IV V-VI