Cosmetic Patient Questionaire

Name: ______________________________ Date: ___________

1. Have you had Botox treatments before? YES NO
   If YES, when was your last Treatment? ______________________

2. Do you have experience with soft-tissue fillers in the past? YES NO
   If YES, Circle what material(s) or filler(s) that were used for your treatment

   Restylane Juvederm Radiesse Pearlane Other____________

   If YES, When was the approximate date of your last dermafiller treatment?

3. Do you have a history of hypertrophic scars or Keloids? YES NO

4. Do you suffer from periodic and/or chronic cold sores? YES NO

5. Do you bruise or bleed easily? YES NO
   Do you take any of the following? Coumadin, aspirin, pradaxa, other blood thinner, Tylenol (acetomenaphen), Motrin(or other ibuprofen), other(please list)

6. Do you have a dermatological condition that exhibits pathergy(pyoderma gangrenosum, sweet's syndrome)? YES NO

7. Do you have any social events coming up within the next week? YES NO

8. What do you hope to achieve from your treatment? (circle all that apply)

   Volume Reduction of Gummy smile

   Youthful appearance Reduction of frown lines

   Wrinkle Reduction Reduction of eye Wrinkles

   Sculpting Reduction of smile lines

Other: ______________________

Comments____
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