ONSPOT DERMATOLOGY

Cosmetic Consult Questionnaire

Patient Name: _____ Date of Birth: _____

What are your cosmetic concerns?
Please check all that apply

- ☐ Blotchy Skin
- ☐ Brown Spots
- ☐ Eye Lash Length
- ☐ Facial Folds
- ☐ Facial Redness
- ☐ Fine Lines/Wrinkles
- ☐ Scarring
- ☐ Skin Tone/Texture
- ☐ Thin Lips
- ☐ Unwanted Chin/Neck Fat
- ☐ Unwanted Hair
- ☐ Veins (Facial or Leg)
- ☐ Other: _____

Which treatment(s) interests you?
Please check all that apply

- ☐ Botox®/Jeuveau®/Dysport®
- ☐ Chemical Peels
- ☐ Dermal Fillers
- ☐ HydraFacial
- ☐ Kybella
- ☐ Microneedling
- ☐ Skin Care Products
- ☐ Other: _____

What cosmetic procedures, if any, have you had in the past? _____

_____

_____

If yes, were you pleased with the results? _____

What skin care products, if any, do you currently use? _____

_____

_____

Do you use Retinol or Retinol-A Gel? _____

Do you have a history of cold sores or gold therapy? _____

Patient Signature: _____ Date: _____

Location: _____ Date: _____