

PIMA DERMATOLOGY

Cosmetic Questionnaire

Date: _____ / _____ / _____

Patient Name: _____ DOB: _____ / _____ / _____

What conditions currently apply to your skin?

- | | |
|--|---|
| <input type="checkbox"/> Uneven Skin Tone | <input type="checkbox"/> Loss of Facial Volume |
| <input type="checkbox"/> Enlarged Pores | <input type="checkbox"/> Aging Neck or Chest |
| <input type="checkbox"/> Acne / Acne Scars | <input type="checkbox"/> "Red Neck" or Chest Redness |
| <input type="checkbox"/> Brown Spots / Pigmentation | <input type="checkbox"/> Unwanted Tattoo(s) |
| <input type="checkbox"/> Red Spots / Facial Veins | <input type="checkbox"/> Stretch Marks |
| <input type="checkbox"/> Unwanted Moles | <input type="checkbox"/> Unwanted Facial Hair / Body Hair |
| <input type="checkbox"/> Fine Lines / Wrinkles | <input type="checkbox"/> Thinning Eyelashes / Eyebrows |
| <input type="checkbox"/> Crow's Feet | <input type="checkbox"/> Tired Eyes / Dark Circles |
| <input type="checkbox"/> Nose to Mouth Lines | <input type="checkbox"/> Surgical Scars / Scars |
| <input type="checkbox"/> Vertical Lip Lines ("Smoker's Lines") | <input type="checkbox"/> Chin / Neck Fullness |
| <input type="checkbox"/> Frown Lines | <input type="checkbox"/> Sun Damage (Hands and Arms) |
| <input type="checkbox"/> Sagging Skin | <input type="checkbox"/> Other: _____ |

Please list the current skin care products you use:

Cosmetic Interest and / or History

- | | |
|--|---|
| <input type="checkbox"/> Dermal Filler Injections | <input type="checkbox"/> Cosmetic Surgery |
| <input type="checkbox"/> BOTOX® Cosmetic Injections | <input type="checkbox"/> LATISSE® |
| <input type="checkbox"/> Chemical Peels / Microdermabrasion in the past year | <input type="checkbox"/> Kybella® |
| <input type="checkbox"/> Laser Treatment(s): _____ | <input type="checkbox"/> Other: _____ |