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COSMETIC INTEREST QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

HEALTH ISSUES, PROCEDURES, OR PRODUCTS OF INTEREST TO YOU: (PLEASE CHECK ALL THAT APPLY)

- BOTOX® Cosmetic
- Parentheses Around Mouth
- Skin Care Advice/Products
- Facial Fine Lines/Wrinkles
- Eyelashes: Longer, Fuller, Darker
- Facial Folds
- Thin Lips
- Blotchy Skin
- Facial Veins
- Facial Redness
- Body Veins
- Liver spots/Age spots
- Birthmark
- Unsightly Moles
- Facial Fullness
- Neck
- Cellulite
- Abdominal Area
- Hips
- Legs
- Facial Hair
- Body Hair

PLEASE ANSWER THE FOLLOWING QUESTIONS ON A SCALE OF 1 TO 5 BY CIRCLING THE APPROPRIATE NUMBER:

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		
1	2	3	4	5

IF YOU COULD IMPROVE ANYTHING ABOUT YOUR APPEARANCE, WHAT WOULD IT BE? _____



HOW DID YOU HEAR ABOUT US?

My Physician: (Full Name) _____

Magazine: (Specify Name of Magazine) _____

A Friend Or Family Member: (Name) _____

The Internet: _____

Our Website:

Seminar: (Specify Seminar/Date) _____

Other: _____

ARE YOU INTERESTED IN SPEAKING WITH THE DOCTOR IN ORDER TO CREATE A PERSONAL TREATMENT PLAN DESIGNED TO MEET YOUR COSMETIC NEEDS?

Yes No Thanks

APPROVAL TO CONTACT YOU:

APPROVAL TO SEND YOU PRODUCT AND SERVICE INFORMATION (INCLUDING SPECIAL OFFERS):

BEST PHONE NUMBER TO CONTACT YOU: _____

EMAIL ADDRESS: _____

PATIENT SIGNATURE: _____

FOR OFFICE USE ONLY

Physician (Provider) Name: _____

FOLLOW-UP: _____ DATE: _____ COMPLETED BY (NAME): _____

Initial Inquiry/Information Method _____

Follow-Up Call: _____

Seminar Participation: _____

Free Consultation: _____

Procedure Scheduled: _____

Procedure Completed: _____

Comments: _____