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COSMETIC QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Have you ever had BOTOX or cosmetic fillers? Yes / No

If yes, what did you have? _____ When? _____

If no, are you interested in learning more about BOTOX and cosmetic fillers? Yes / No

Do you currently have a skin care regimen? Yes / No

If yes, what are you using? _____

Are you receiving the improvement you hoped for from your skin care regimen? Yes / No

Would you like to receive a complimentary skin care consultation with our aesthetician? Yes / No

Would you like to be contacted by phone or email regarding specials or events at our medical spa? Yes / No

If yes, what is your name and email address: _____

Telephone number: _____