Patient Consultation Questionnaire

Name:___________________________________ DOB: _____________________

Circle: Male

Female

- circle: pre or post menopausal? Pregnant or planning to become pregnant?

1. List your top 5 concerns in order of priority:

__Sagging Skin (circle: face/neck/body)

__Wrinkles

__Pigmentation (circle: Sun Spots/Melasma)

__Acne/Breakouts

__Redness/Rosacea

__ Hair Removal

__Hair Loss

__Sun Damage

__Under-eye circles/bags

__Thinning Lips/Peri-oral area

__Improved Overall Wellness

__Hormone Balance

__Weight Loss

__Tattoo Removal

__ Fat Reduction (Circle: chin/abdomen/love handles/legs/arms)

__Feminine Rejuvenation

__ General Skin Maintenance

2. **The concerns I have noted above are currently affecting my**: (check all that apply)
   __Self-esteem __Confidence __Ability to succeed in my workplace __Marriage/Relationships
   __Other: ____

3. **I want to**: (check one)
   __ Look *Younger* __Look More *Refreshed* __Look *Healthier*

4. **My best feature is**: (check one)
   __My eyes __My hair __My smile __My body (which part?_________) __Other _________

5. **My worst feature is**: (check one)
   __My eyes __My hair __My smile __My body (which part?_________) __Other _________

6. **My skin tends to be**: (check all that apply)
   __Oily __Dry __Combination __Sensitive

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7. **The Pigment/Undertone in my skin is**: (check one)
   __Brown __Red __White __Blue/Cool __Yellow __None of above

8. **I smoke cigarettes/cigars**: (check one)
   __Yes (how many packs per days? _____) __No __Occasional Smoker

9. **I go in the sun**: (check one)
   __Frequently __Sometimes __Rarely __Never

10. **I use SPF**: (check one)
    __Daily __On days that I know I'll be outside for longer periods of time __Rarely __Never

11. **I use Retinol/Retin-A/Tretinoin products**: (check one)
    __Daily __On occasion __Rarely __Never

12. **When it comes to skin care products, I prefer**: (check one)
    __The fewest # of products possible ("Keep it Simple")
    __Whatever I need to get the job done
    __I'll try anything….More is MORE, right? (Skin-care "junky")

13. **I work outside of the home**: (check all that apply):
    __< 20 hrs/wk __20-30 hrs/wk __30-40 hrs/wk __>40 hrs/wk
    __I don't work outside of the home (retired, stay –at-home parent, etc)
    __I work from home

14. **My preference with in-office treatments is to**: (check one)
    __ Get the job done with the fewest # of treatments possible, even if those treatments may result in more downtime (time off from work/life to heal)
    __Get treatments that require the least amount of downtime, even if that may require more treatment sessions to achieve my desired result.

15. **My tolerance of procedures that require injections/needles is**: (check one)
    __I am fine with injections/needles
    __I don't like injections, but I'll do them if I have to
    __I do not tolerate injections/needles (pass out, etc.)

16. **If I could, I would want to look**: (check one)
    __3-5 years younger __5-10 years younger __Not *younger*, just more refreshed

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17. **If I had treatments done in the office, I**: (check one)
    __Wouldn't want anyone to know
    __Would tell only my closest friends/relatives
    __Would tell anyone who asked (and even those that don't ask)

18. **I consider myself**: (check one)
    __very healthy & fit __basically healthy & fit __not healthy & fit
    __healthy, but not fit __fit, but not healthy

19. **If I could, I would want to lose**: (check one)
    __0-5 lbs __5-10 lbs __10-20 lbs __20-40 lbs __40 or more lbs __I am happy with my weight

20. **I am experiencing the following symptoms**: (check all that apply)
    __insomnia __weight gain __weight loss __hot flashes __mood swings __lower libido
    __decreased exercise endurance __anxiety __depression __difficulty with erection +/-orgasm
    __memory loss/brain fog __loss of motivation __joint pain __bloating __painful intercourse
    __difficulty focusing __gastrointestinal upset __food sensitivities

21. **My preference with regards to nutritional supplements is**: (check one)
    __I don't/won't take them (can't swallow pills, history of allergic reactions, etc.)
    __I am willing to take what I need in order to feel my best, but don't currently use supplements
    __I am currently taking supplements and am willing to take whatever I need to improve my health

22. **Are there any special events/occasions coming up that you would like to look your best for**?(check one) __ No __Yes (if so, which event/occasion? ___________________)

23. **My budget is**: (check one)
    __ $500 - $1000 __$1000-$3000 __$3000-$5000 __$5000-$10,000

24. **My time line to get started is**: (check one)
    __6-12 months __3-6 months __0-3 months

Thank you for taking the time to fill out this questionnaire. The answers you have provided will help us to determine the best treatment options for you to reach your goals.

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