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## COSMETIC INTEREST QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Acne                    | <input type="checkbox"/> Facial Waxing         | <input type="checkbox"/> Restylane®             |
| <input type="checkbox"/> Acne Scarring           | <input type="checkbox"/> Hair Removal          | <input type="checkbox"/> Sculptra™              |
| <input type="checkbox"/> Anti-Aging Treatments   | <input type="checkbox"/> Juvederm™             | <input type="checkbox"/> Skin Care Advice       |
| <input type="checkbox"/> Birthmarks              | <input type="checkbox"/> Laser Resurfacing     | <input type="checkbox"/> Skin Care Products     |
| <input type="checkbox"/> BOTOX® Cosmetic         | <input type="checkbox"/> Liver Spots/Age Spots | <input type="checkbox"/> Skin Rejuvenation      |
| <input type="checkbox"/> Cellulite Treatment     | <input type="checkbox"/> Microdermabrasion     | <input type="checkbox"/> Skin Tightening        |
| <input type="checkbox"/> Chemical Peels          | <input type="checkbox"/> Radiesse®             | <input type="checkbox"/> Spider Vein Treatments |
| <input type="checkbox"/> Facial Veins Treatments | <input type="checkbox"/> Radio Frequency       | <input type="checkbox"/> Sunscreen Advice       |

Other, please specify: \_\_\_\_\_

### HAVE YOU PREVIOUSLY HAD ONE OF THE FOLLOWING?

BOTOX® Cosmetic	<input type="checkbox"/> YES <input type="checkbox"/> NO	Areas Treated: _____	Date: _____
Chemical Peel	<input type="checkbox"/> YES <input type="checkbox"/> NO	Type of Peel: _____	Date: _____
Cosmetic Fillers	<input type="checkbox"/> YES <input type="checkbox"/> NO	Areas Treated: _____	Date: _____
		Type of Filler: _____	
Facial Surgery	<input type="checkbox"/> YES <input type="checkbox"/> NO	Procedure: _____	Date: _____
Laser Resurfacing	<input type="checkbox"/> YES <input type="checkbox"/> NO	Type/Depth: _____	Date: _____
Microdermabrasion	<input type="checkbox"/> YES <input type="checkbox"/> NO		

What sunscreen products do you currently use? Face: \_\_\_\_\_ Body: \_\_\_\_\_

What skin care products do you use frequently? \_\_\_\_\_

### HOW DO YOU TAN?

- |   |  |
|---|--|
| <input type="checkbox"/> I Burn             | <input type="checkbox"/> IV Rarely Burn          |
| <input type="checkbox"/> II Usually Burn    | <input type="checkbox"/> V Never Burn – “Brown”  |
| <input type="checkbox"/> III Sometimes Burn | <input type="checkbox"/> VI Never Burn – “Black” |

### FACIAL WRINKLES:

- |  |   |
|--|---|
| <input type="checkbox"/> Deep Wrinkles | <input type="checkbox"/> Fine Lines                         |
| <input type="checkbox"/> Crow's Feet   | <input type="checkbox"/> Peri-oral Lines (around the mouth) |

### SKIN TYPE:

Does your skin ever flake and feel tight and dry?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Very Rarely
Is your skin ever dry a few hours after cleansing?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Very Rarely
How often do you experience blackheads or blemishing?	<input type="checkbox"/> Frequently	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Very Rarely
How noticeable are your pores?	<input type="checkbox"/> Very	<input type="checkbox"/> T-Zone	<input type="checkbox"/> Not Very