Howard L. Brooks, M.D.
Cosmetic-Medical Dermatology,
202.298.7546
Georgetown Plaza
2233 Wisconsin Ave., NW Suite 230
Washington, DC 20007

COSMETIC QUESTIONNAIRE

PATIENT NAME: ______________________________ DATE: ______________

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

- BOTOX Cosmetic
- Smile Lines
- Skin Care Products
- Facial Fine Lines/Wrinkles
- Eyelashes: Longer, Fuller, Darker
- Facial Folds
- Thin Lips
- Blotchy Skin
- Facial Veins
- Facial Redness
- Leg Veins
- Age Spots/Brown Spots
- Eye Brow Lift
- Facial Fullness
- Neck
- Abdominal Fat
- Facial Hair
- Body Hair
- Acne
- Rosacea
- Chemical Peel
- Facials
- Lip Enhancement
- Loose Skin
- Uneven Complexion
- Cheek Augmentation

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		Very Concerned
1	2	3	4	5

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

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HOW DID YOU HEAR ABOUT US?

My Physician: (Full Name) ____________________

My Insurance Company Provider: (Name) ____________________

Magazine: (Specify Name of Magazine) ____________________

A Friend Or Family Member: (Name) ____________________

The Internet: ____________________

Our Website: ◇ Yes ◇ No

Other: ____________________

PATIENT SIGNATURE: ____________________

FOR OFFICE USE ONLY

Physician (Provider) Name: ____________________

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

Follow-Up Call: ____________________

Free Consultation: ____________________

Procedure Scheduled: ____________________

Procedure Completed: ____________________

Comments: ____________________

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