SKIN CARE QUESTIONNAIRE – so we may better serve you

Patient Name:____________________________ Date_____________________

Please circle your concerns

Acne	Facial Folds	Skin Texture/Dullness
Facial Redness	Skin Tone	Scarring
Bruising	Pigmentation	Under Eye Circles
Wrinkles	Wrinkle Folds	Unwanted Hair
Facial Veins		

Other____

Please circle if you want to know more about

Botox	Filler	Photofacial
Laser	Photodynamic therapy	Ultherapy
Facials	Microdermabrasion	Chemical Peels
Dermapen	Electrolysis	Isolaz

What is your present skin care regimen?

AM ____________________ ____________________ ____________________

PM ____________________ ____________________ ____________________

Would you be interested in meeting with one of DOCs'cosmetic consultants to create a complimentary personal treatment plan designed to your personal cosmetic needs?

YES NO THANKS

Best phone number to reach you:_________________________________

Email: ____

Patient Signature:____ Date:_______________________

WE APPRECIATE THAT YOU TOOK THE TIME TO SHARE YOUR THOUGHTS WITH US!