Sonterra Dermatology PLLC
Annabelle L. García, M.D.

COSMETIC INTEREST QUESTIONNAIRE

Name:_____ Date:_____

What of the following general appearance conditions would you like to learn about? (Please check all that apply)

- ❑ Skin care advice
- ❑ Skin care products
- ❑ Facial Wrinkles (Botox)
- ❑ Facial fine lines (Fillers)
- ❑ Thin lips
- ❑ Blotchy skin
- ❑ Chemical peel
- ❑ Facial hair reduction
- ❑ Body hair reduction
- ❑ Other:_____
- ❑ Facial veins
- ❑ Facial redness
- ❑ Brown spots/age spots/freckles
- ❑ Drooping brow
- ❑ Drooping eyelids
- ❑ Facial fullness/drooping
- ❑ Mole removal
- ❑ Acne scarring
- ❑ Leg veins
- ❑ Neck wrinkles
- ❑ Brow lift
- ❑ Chest wrinkles
- ❑ Abdominal area
- ❑ Inner / outer leg contouring
- ❑ Facial contouring
- ❑ Body contouring
- ❑ Arm contouring
- ❑ Length/Fullness of Eyelashes

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

How did you hear about us?

- ❑ Another physician
- Physician Name:_____
- ❑ A friend or family member
- Name:_____
- ❑ Facebook
- ❑ Sonterra Dermatology website
- ❑ My insurance company
- Name:_____
- ❑ Internet
- Site:_____
- ❑ Other
- Specify:_____

Are you interested in meeting with our medical / cosmetic aesthetician to create a personal treatment plan designed to meet your cosmetic needs?

❑ YES ❑ No, thanks

❑ Permission to contact you. **(Please note: Your personal information is never shared with outside parties)**

Best phone number to reach you:_____ Email address:_____

❑ Permission to send you information on products and services (including special offers)

Would you prefer electronic confirmation of your appointment? ❑ Yes ❑ No

Would you prefer electronic notification of specials? ❑ Yes ❑ No

Patient Signature:_____ Date:_____

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