

Jerome R. Potozkin, M.D.

Cosmetic Interest Questionnaire

Patient Name:		Date:	
What is the reason for your visit today?			
Other than the services we have provided for you, what additional services would you like to learn about? (Please check all that apply)			
<input type="checkbox"/> Skin care advice <input type="checkbox"/> Skin care products <input type="checkbox"/> BOTOX®/Dysport® <input type="checkbox"/> Restylane®/Juvederm® <input type="checkbox"/> Facial lines/wrinkles <input type="checkbox"/> Thin lips <input type="checkbox"/> Blotchy skin <input type="checkbox"/> Chemical Peel <input type="checkbox"/> Eyelid Surgery	<input type="checkbox"/> Facial veins <input type="checkbox"/> Facial redness <input type="checkbox"/> Brown spots/freckles <input type="checkbox"/> Drooping brow <input type="checkbox"/> Drooping eyelids <input type="checkbox"/> Nose shape <input type="checkbox"/> Facial fullness <input type="checkbox"/> Mole removal <input type="checkbox"/> Scar revision	<input type="checkbox"/> Neck wrinkles <input type="checkbox"/> Abdominal area <input type="checkbox"/> Hips <input type="checkbox"/> Acne scarring <input type="checkbox"/> Liposculpture <input type="checkbox"/> Laser hair removal <input type="checkbox"/> Tattoo removal <input type="checkbox"/> Length/fullness of eyelashes <input type="checkbox"/> Leg veins	
What cosmetic procedures, if any, have you had in the past?			
If you have previously had any cosmetic procedures, were you pleased with the outcome?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			
If our office hosted an event to inform patients about cosmetic procedures or products, would you be interested in attending?			
<input type="checkbox"/> Yes <input type="checkbox"/> No			

Thank you for your time