



# Lincoln Aesthetic Surgical Institute

## Cosmetic Interest Questionnaire

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**Please check any of the following health topics, procedures, products, and body areas of concern or interest to you.**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Skin care advice                   | <input type="checkbox"/> Eyelashes; Longer, Fuller, Darker | <input type="checkbox"/> Neck wrinkles     |
| <input type="checkbox"/> Skin care products                 | <input type="checkbox"/> Brown spots/age spots/freckles    | <input type="checkbox"/> Breast size       |
| <input type="checkbox"/> BOTOX® Cosmetic                    | <input type="checkbox"/> Drooping brow                     | <input type="checkbox"/> Abdominal area    |
| <input type="checkbox"/> Facial Fillers: Juvéderm /Radiesse | <input type="checkbox"/> Drooping eyelids                  | <input type="checkbox"/> Hips              |
| <input type="checkbox"/> Facial fine lines/wrinkles         | <input type="checkbox"/> Nose size or shape                | <input type="checkbox"/> Legs              |
| <input type="checkbox"/> Laser skin resurfacing             | <input type="checkbox"/> Ear size or shape                 | <input type="checkbox"/> Facial Contouring |
| <input type="checkbox"/> Thin lips                          | <input type="checkbox"/> Facial fullness/drooping          | <input type="checkbox"/> Body Contouring   |
| <input type="checkbox"/> Blotchy skin                       | <input type="checkbox"/> Mole removal                      |  |
| <input type="checkbox"/> Chemical peel                      | <input type="checkbox"/> Scar revision                     |  |
| <input type="checkbox"/> OTHER: _____                       |  |  |

**Please answer the following questions on a scale of 1 to 5 by marking 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.**

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

**When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.**

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

**When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my body.**

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5

**How did you hear about us? Check all that apply.**

- |  |                  |
|--|------------------|
| <input type="checkbox"/> My physician  | Full name:       |
| <input type="checkbox"/> My insurance company provider                             | Name:            |
| <input type="checkbox"/> The yellow pages  | Specify Ad:      |
| <input type="checkbox"/> A friend or family member                                 | Name:            |
| <input type="checkbox"/> Internet Search Engine                                    | Please specify:  |
| <input type="checkbox"/> Lincoln Aesthetic Surgical Institute Website              |                  |
| <input type="checkbox"/> Seminar   | Date & Location: |
| <input type="checkbox"/> Other Website (i.e., LoveYourLook, PhysicianFinder, etc.) | Please specify:  |
| <input type="checkbox"/> Other   | Please specify:  |

Would you like to receive announcements on special discounts, new products or procedures?

- Yes       No

If YES, what address can we send it to? \_\_\_\_\_

Would you like to receive this information via an email address?

- Yes       No

If YES, please list email address ([name@example.com](mailto:name@example.com)) \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_