DOCs
Dermatology & Oculoplastic Consultants

SKIN CARE QUESTIONAIRE

Patient Name:_____ Date: _____

General appearance or products of interest to you (please circle all that apply).

Acne	Facial veins	Psoriasis
Botox Cosmetic	Facial wrinkles	Scarring
Bruising	Fillers	Skin care advice / products
Drooping eyelids	Laser: Fractionated resurfacing	Skin texture / tone
Eyelash fullness	Laser: Hair removal	Sun spots
Facial folds	Laser: IPL / Photofacial	Under eye circles
Facial redness	Pigmentation	Other: _____

For the following statements, please circle the number that reflects your opinion with 1 being you agree the <u>MOST</u> with the phrase and 5 being you agree the <u>LEAST</u> with the phrase.

I would like to improve the condition and appearance of my skin.

1 2 3 4 5

Are you satisfied with your skin-care regimen?

1 2 3 4 5

What is your present skin-care regimen?

AM _____ _____ _____

PM _____ _____ _____

Would you be interested in meeting with one of DOCs' cosmetic consultants, in order to create a **<u>Complimentary</u>** Personal Treatment Plan designed to meet your cosmetic needs?

Yes No Thanks

___ Approval to contact you. Best phone number to reach you: _____

Email address: _____

Patient Signature: _____ Date: _____

WE APPRECIATE THAT YOU TOOK THE TIME TO SHARE YOUR THOUGHTS WITH US!
WE LOOK FORWARD TO HELPING KEEP AN "EYE ON YOUR SKIN!".....

IN OFFICE USE: ___ PICTURES ___ SKIN ANALYSIS a.) b.)