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Facial Rejuvenation Questionnaire

Patient Name:____
Date: ____

What facial changes or improvements are you considering?____

____
____

Have you ever had any previous facial cosmetic surgery (including laser)? Yes _____ No_____

If yes, please explain:____
____

____
____

Do you have any skin sensitivities? Yes _____ No_____

If so, please specify:
____
____

Do you sunburn easily? Yes _____ No_____

Do you have a bleeding tendency? Yes _____ No_____

Do you bruise easily? Yes _____ No_____

Do you smoke? Yes _____ No_____ If so, how much/how often?_____________________________

Do you get dry eyes? Yes _____ No_____

Do you get cold sores? Yes _____ No_____

Have you ever taken Acutane? Yes _____ No_____

Have you had Botox injections? Yes _____ No_____ If so, when was the last?_______________________________

Have you had Collagen/Fillers? Yes _____ No_____ If so, when was the last?_______________________________

Are you allergic to any medications? Yes _____ No_____

If so, please list.____

Are you currently taking any medications? Yes _____ No_____

If so, please list.____