

COSMETIC INTEREST QUESTIONNAIRE

COASTAL HAS EXPANDED TO INCLUDE A NEW DIVISION :

COASTAL FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY

WITH DR. ANTHONY SPARANO, A FELLOWSHIP-TRAINED FACIAL PLASTIC SURGEON. IF YOU ARE INTERESTED IN LEARNING MORE, PLEASE FEEL FREE TO COMPLETE THE BELOW QUESTIONNAIRE.

Patient Name: _____

Date: _____

Areas or products of interest to you (please check all that apply).

<input type="checkbox"/> Skin care advice <input type="checkbox"/> Skin care products <input type="checkbox"/> BOTOX® Cosmetic <input type="checkbox"/> Facial fine lines <input type="checkbox"/> Facial wrinkles <input type="checkbox"/> Facial folds <input type="checkbox"/> Thin lips <input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Facial veins <input type="checkbox"/> Leg veins / Body veins <input type="checkbox"/> Facial redness <input type="checkbox"/> Liver spots/age spots <input type="checkbox"/> Birthmark <input type="checkbox"/> Permanent facial hair removal <input type="checkbox"/> Permanent body hair removal <input type="checkbox"/> Acne scarring	<input type="checkbox"/> Facial droop / skin laxity <input type="checkbox"/> Sagging or displeasing eyelids <input type="checkbox"/> Neck <input type="checkbox"/> Nose <input type="checkbox"/> Longer Eyelashes <input type="checkbox"/> _____ <input type="checkbox"/> _____
--	---	---

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.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about having an aged appearance.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

Have you heard of Coastal Facial Plastic and Reconstructive Surgery before? If so how?

<input type="checkbox"/> Another physician	Name: _____
<input type="checkbox"/> Friend or family member	Name: _____
<input type="checkbox"/> Office staff	Name/Area (front desk, nurse, phone, MD): _____
<input type="checkbox"/> Internet	_____
<input type="checkbox"/> Seminar/Lecture	Which: _____
<input type="checkbox"/> Radio	_____
<input type="checkbox"/> Billboard	_____
<input type="checkbox"/> Other	Please specify: _____

<input type="checkbox"/> Approval to contact you	Best phone number to reach you: _____
<input type="checkbox"/> Approval to send you information on products, services, promotions, and special offers	E-mail address: _____

Patient Signature: _____

Date: _____

For Office Use Only

<i>Follow-up</i>	<i>Date</i>	<i>Completed by (name)</i>
<input type="checkbox"/> Follow-up call	_____	_____
<input type="checkbox"/> E-mail of services / special offers	_____	_____
<input type="checkbox"/> Seminar invitation	_____	_____
<input type="checkbox"/> Consultation scheduled	_____	_____

Comments: _____