

**COSMETIC QUESTIONNAIRE**

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

Reason for Consultation: \_\_\_\_\_

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Do you Smoke:      Yes                  No    (circle)

Have you had any cosmetic procedures in the past:      Yes                  No    (circle)

Procedure \_\_\_\_\_

Approximate Date \_\_\_\_\_

Procedure \_\_\_\_\_

Approximate Date \_\_\_\_\_

Where you satisfied with the outcome of prior cosmetic procedure:    Yes      No\*    (circle)

\*please explain: \_\_\_\_\_

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Have you ever had sun blisters or fever blisters: Yes\* / No (circle) \*date of last episode \_\_\_\_\_

Have you ever had a herpes infection:                  Yes\* / No (circle) \*date of last episode \_\_\_\_\_

Please provide additional information that we should know below: