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COSMETIC PATIENT QUESTIONAIRE
PLEASE PRINT IN INK

Name: _____ Age: _____ Referred By: _____

Please tell us the cosmetic concern that brings you to see Dr. Hamilton or our PA today:

_____

_____

_____

PRIOR COSMETIC SURGERY HISTORY
Please list all cosmetic surgical procedure (including injections or implants) that you have had done, the date, and the doctor who performed the procedure. Please note any complications.

_____

_____

_____

PAST MEDICAL HISTORY
Do you have any health problems? YES / NO Please list them:

_____

What medicine do you take (include any substance which you take by mouth other than food)?

_____

_____

What medicine are you allergic to (if any)?

_____

_____

_____

DO YOU HAVE ANY ELECTRICAL IMPLANTS (PACEMAKERS, COCHLEAR IMPLANTS)? YES / NO

DO YOU HAVE ANY FACIAL IMPLANTS (CHIN, CHEEK OR GORTEX)? YES / NO

Check off all the things that concern you:

FACE ISSUES

- ☐ Wrinkles
- ☐ Scars
- ☐ Brown spots
- ☐ Redness
- ☐ Sun damage
- ☐ Broken blood vessels
- ☐ Deep smile lines
- ☐ Dark under eye circles
- ☐ Deep forehead lines
- ☐ Sagging brows
- ☐ Sagging facial skin
- ☐ Loose neck skin
- ☐ Jowls
- ☐ Sunken cheeks
- ☐ Small cheekbones
- ☐ Thin lips
- ☐ Nose bump
- ☐ Facial hair
- ☐ Daily skin care

BODY ISSUES

- ☐ Body sun damage
- ☐ Cellulite
- ☐ Stretch marks
- ☐ Loose body skin
- ☐ Pockets of fat (e.g. love handles)
- ☐ Spider veins of the legs
- ☐ Varicose veins
- ☐ Aged hands
- ☐ Body hair