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**Cosmetic Interest Questionnaire: What are your concerns with your skin/appearance? Please check all that apply:**

- Forehead Wrinkles
- Frown Lines
- Bunny Lines
- Crow's Feet
- Nasolabial Folds (nose to mouth lines)
- Vertical Lip Lines (Smoker's Lines)
- Marionette Lines (corners of mouth to jaw)

**Pigmentation/spots**

- Broken Capillaries
- Redness or Rosacea
- Under Eye Dark Circles
- Freckles and Pigmentation (brown spots)
- Loss of Skin Vibrancy

**Other:**

- Scarring
- Acne Lesions
- Dry Skin
- Oily Skin
- Lip Volume
- Cellulite
- Thinning Eyelashes
- Neck Laxity
- Jaw Laxity
- Keloid

**Fitzpatrick skin type (select one): \***

- GRADE I - Pale white skin, blue/green eyes, blond/red hair. - Always burns, does not tan
- GRADE II - Fair skin, blue eyes. - Burns easily, tans poorly
- GRADE III - Darker white skin. - Tans after initial burn
- GRADE IV - Light brown skin. - Burns minimally, tans easily
- GRADE V - Brown skin. - Rarely burns, tans darkly easily
- GRADE VI - Dark brown or black skin. - Never burns, always tans darkly

**Do you experience these conditions on your skin? Select all that applies: \***

- |                                    |                                    |                              |
|------------------------------------|------------------------------------|------------------------------|
| <input type="checkbox"/> Flakiness | <input type="checkbox"/> Breakouts | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Oiliness  | <input type="checkbox"/> Brusing   |                              |
| <input type="checkbox"/> Tightness | <input type="checkbox"/> Redness   |                              |

**Are you using acne/aging products (oral or topical)? Select all that applies: \***

- |                                   |                                   |                               |
|-----------------------------------|-----------------------------------|-------------------------------|
| <input type="checkbox"/> Retin-A  | <input type="checkbox"/> Azelex   | <input type="checkbox"/> None |
| <input type="checkbox"/> Differin | <input type="checkbox"/> Accutane |                               |
| <input type="checkbox"/> Renova   | <input type="checkbox"/> Other    |                               |

**Have you ever had a reaction to any of the following? Select all that applies: \***

- |  |  |                              |
|--|--|------------------------------|
| <input type="checkbox"/> Shelfish/Iodine | <input type="checkbox"/> Fragrances/Dyes | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Sunscreens      | <input type="checkbox"/> Makeup          |                              |
| <input type="checkbox"/> Medicine        | <input type="checkbox"/> AHA's           |                              |

**Do you currently have any skin ailments (Eczema, Poison Ivy, Etc.)? \***

**What is your primary goal or improvements you would like to see? \***

**What skin care program are you currently using (cleanser, exfoliator, etc.)? \***

Do you sun bathe or use tanning beds?

- Yes
  No

Are you using oral contraceptives?

- Yes
  No

Do you use sunscreen?

- Yes
  No

Have you had Microdermabrasion, chemical peels or laser peels before?

- Yes
  No

Do you smoke (including socially)?

- Yes
  No

Do you follow a specialized diet?

- Yes
  No

Are you currently having or due for your menstrual cycle?

- Yes
  No
 N/A

	Yes	No	N/A
Are you pregnant or considering becoming pregnant in the future?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Are you breastfeeding?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Have you started any new medication, treatments or skin care products?

- Yes
  No

Will you be returning to work or another social setting after your treatment session today?

- Yes
  No

*Please Read This Form Carefully and Completely Before Signing It*

I, , understand that I have a condition that requires medical treatment.

I confirm that to the best of my knowledge, my answers are correct and I have not withheld any information. I will inform my practitioner of any changes in my health or lifestyle which may affect my treatments.

I authorize to determine what kinds of diagnostic procedures (tests) must be done in order to learn more about my condition. These may include electrocardiograms, ultrasounds, blood tests, blood pressure, or other routine tests. I understand that if my doctor advises a more complex test or one which has special risk, it will be explained to me. Further, I authorize the personnel of to assist in giving or to give the tests which my doctor will order.

I also authorize my doctor to determine what kind of treatment is to be given, and to perform such procedures as he/she may deem necessary, in his/her professional judgment, to preserve my health. Additionally, I authorize the personnel of to assist in giving the treatment which my doctor will order. I fully understand that medical tests or treatments may involve certain unavoidable risks.

If part of my treatment is very complex or carries special risks, it will be explained to me.

I understand that it is not practical to list every aspect of medical care, nor every procedure or treatment which I might receive. However, I acknowledge that my doctor is available to answer my questions I might have. I understand that the practice of medicine and surgery are not exact sciences, and acknowledge that no guarantee or assurance has been made to me as a result of treatments or examination.

**Financial Responsibility Agreement**

THE UNDERSIGNED agrees whether he/she signs as parent, spouse, guarantor, guardian, or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, I authorize attorney to obtain my credit report: and the undersigned shall pay reasonable attorney's fees and collection expenses.

**Authorization to Release Photographs and Treatment Details**

I give permission to to photograph the areas I would like treated, both before and after sclerotherapy. I understand these photographs will be used to monitor the progress of my treatments and may be used for marketing or other medical purposes. I understand that if used for marketing or medical research purposes these photographs will not contain my name or other identifying information, and I understand that I will not be entitled to any payment or other forms of remuneration as a result of any use of the photographs.

I also grant consent to to send and disclose all before and after photos of my evaluations and procedures as well as treatment details and progress notes to my primary health care physician.

Photographs can or may be used for marketing purposes, do you accept?

- Yes
- No

05/22/2025 - I certify that I have read this form, and had it explained to me, and certify that I fully understand its contents. \*

Tap here to sign