LINNELL

DERMATOLOGY | AESTHETICS

COSMETIC CONSULTATION QUESTIONNAIRE

This form must be completed by the time of your cosmetic consultation. Please bring this sheet to your visit or send it to our clinic prior to your visit

Email: info@linnellderm.com or Text: 206-539-0675

Name: ____**Date of Birth:** ______________

What are your cosmetic concerns?

Please check all that apply:

- ◻ Blotchy Skin
- ◻ Brown Spots
- ◻ Eyelash Length
- ◻ Facial Folds
- ◻ Facial Redness
- ◻ Fine Lines/Wrinkles
- ◻ Scarring
- ◻ Skin Tone/Texture
- ◻ Skin Laxity
- ◻ Body Concerns:
  - ◻ Skin laxity
  - ◻ Lack of muscle
  - ◻ Small areas of stubborn fat
- ◻ Thin Lips
- ◻ Unwanted Chin/Neck Fat
- ◻ Unwanted Hair
- ◻ Unwanted Tattoos
- ◻ Veins (Facial/Leg)
- ◻ Other (Please specify): ___________________

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What treatment(s) interest you?

Please check all that apply:

- ◻ Neurotoxin (Dysport/Botox/Daxxify)
- ◻ Dermal Fillers
- ◻ Picoway Laser (Brown Spots/Tattoo Removal)
- ◻ VBeam Laser (Redness, Rosacea)
- ◻ Ultraclear Laser (Overall rejuvenation & resurfacing)
- ◻ Aviclear Laser (Acne)
- ◻ LaseMD Laser (Resurfacing)
- ◻ Morpheus8 (Microneedling with Radiofrequency to tighten, lift)
- ◻ Microneedling
- ◻ Laser Hair Removal (LHR)
- ◻ Body Sculpting (Emsculpt, Exilis, Emtone)
- ◻ Kybella (to dissolve fat)
- ◻ Platelet Rich Plasma (PRP) Services
- ◻ Exosomes
- ◻ Sclerotherapy
- ◻ Removal of Benign Lesions
- ◻ Chemical Peels
- ◻ Cosmetic Mole Removal
- ◻ Skin Care Products
- ◻ Other: _______________________________

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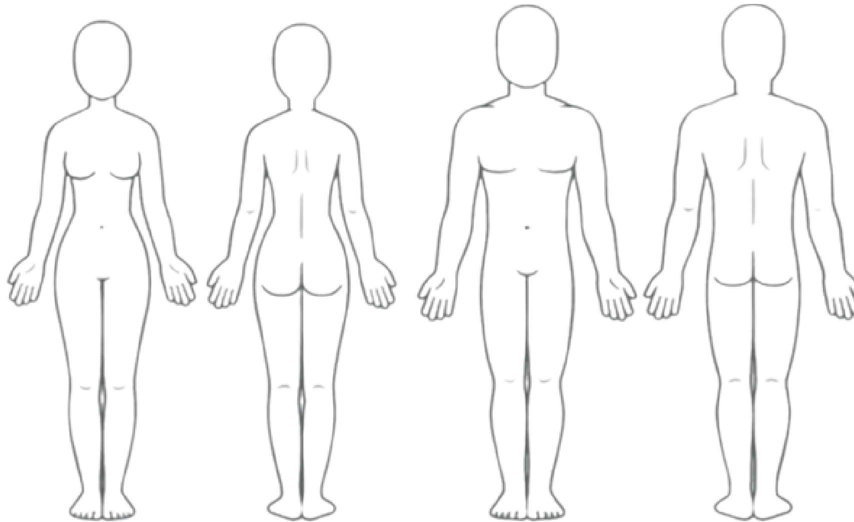
Please circle any areas of concern on the diagram below:



GENERAL QUESTIONS:

1. What cosmetic procedures, if any, have you had in the past? ______________________________
   ____
   ____
   ____
2. If yes, how many treatment sessions did you receive and were you pleased with your results? (Please skip this question or write "N/A" if you did not have any previous cosmetic procedures)
   ____
   ____
   ____
3. What skin care products, if any, do you currently use? ______________________________
   ____
   ____
4. Do you use a Retinol or Retinoid cream? ______________________________
5. Do you have a history of cold sores or gold therapy? (Check one): ◻ Yes ◻ No
6. Are you taking or have you ever taken Accutane? (Check one): ◻ Yes ◻ No
   When?: ____________ Did you complete a full course - 6 months? (Check one): ◻ Yes ◻ No
7. Are you currently pregnant or nursing? (Check one): ◻ Yes ◻ No
8. Are you planning on becoming pregnant soon? (Check one): ◻ Yes ◻ No
9. Do you smoke or have a history of smoking? (Check one): ◻ Yes ◻ No
   If yes, how long? ________________
10. Do you have any allergies to benzocaine, lidocaine, tetracaine or epinephrine?
    (Check one): ◻ Yes (please specify): ______________________________ ◻ No