



GRAPER
COSMETIC
SURGERY

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COSMETIC INTEREST QUESTIONNAIRE

Patient Name:

Date:

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

<input type="checkbox"/> Aging Face <input type="checkbox"/> Neck <input type="checkbox"/> Jowls (sagging cheeks) <input type="checkbox"/> Drooping eyelids <input type="checkbox"/> Chin/Cheek contour changes <input type="checkbox"/> Nose <input type="checkbox"/> Breast Augmentation <input type="checkbox"/> Breast Lift/Reduction <input type="checkbox"/> Abdominal area <input type="checkbox"/> Hips <input type="checkbox"/> Legs <input type="checkbox"/> Skin Care Advice	<input type="checkbox"/> Skin care products <input type="checkbox"/> BOTOX [®] Cosmetic <input type="checkbox"/> Juvéderm [®] <input type="checkbox"/> Restylane [®] <input type="checkbox"/> Facial fine lines <input type="checkbox"/> Facial wrinkles <input type="checkbox"/> Thin lips <input type="checkbox"/> Blotchy skin <input type="checkbox"/> Facial veins <input type="checkbox"/> Facial redness <input type="checkbox"/> Liver spots/age spots <input type="checkbox"/> Rough texture of skin	<input type="checkbox"/> Tired looking skin <input type="checkbox"/> Sagging skin <input type="checkbox"/> Unwanted hair <input type="checkbox"/> Uneven skin tone <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Dark circles under eyes <input type="checkbox"/> Acne <input type="checkbox"/> Freckles <input type="checkbox"/> Dry Skin <input type="checkbox"/> Sclerotherapy/Leg Veins <input type="checkbox"/> Micropigmentation/Permanent Makeup <input type="checkbox"/> Other _____
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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 the appearance of my wrinkles.

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

Are you interested in meeting with one of our Licensed Medical Aestheticians or Certified Nurse Injectors in order to create a Personal Treatment Plan designed to meet your cosmetic needs?

YES No thanks

Would you like to receive e-mails from our office about special opportunities and savings?

If so, please provide your current email address below.

Email address: _____

<input type="checkbox"/> Approval to contact you.	<i>Best phone number to reach you:</i>
<input type="checkbox"/> Approval to send you information on products and services (including special offers)	<i>Email address:</i>

Patient Signature: _____

Date: _____

**Our practice offers many options to meet your financial needs.
Please check those that are of interest to you.**

<input type="checkbox"/> Cash <input type="checkbox"/> Check	<input type="checkbox"/> Credit Card <input type="checkbox"/> Debit Card	<input type="checkbox"/> Financing <input type="checkbox"/> Other _____
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