OSBORNE HEAD & NECK institute
Ear, Nose & Throat Specialists

Patient Name: _____ Date: _____

HEALTH ISSUES, PROCEDURES. OR PRODUCT OF INTEREST TO YOU:

- ☐ BOTOX COSMETIC
- ☐ SKIN CARE ADVICE/ PRODUCT
- ☐ FACIAL FINE LINES/ WRINKLES
- ☐ EYELASHES: LONGER, FULLER, DARKER
- ☐ FACIAL FOLDS
- ☐ THIN LIPS
- ☐ BLOTCHY SKIN
- ☐ FACIAL VEINS
- ☐ FACIAL REDNESS
- ☐ BIRTHMARK
- ☐ MOLE REMOVAL
- ☐ FACIAL FULLNESS
- ☐ FACIAL HAIR
- ☐ CHEMICAL PEEL
- ☐ SCAR REVISION
- ☐ JUVEDERM/ OTHER FILLERS
- ☐ NOSE SIZE OR SHAPE
- ☐ DROOPING BROW
- ☐ DROOPING EYELID
- ☐ BROWN SPOTS/ FRECKLES
- ☐ CELLULITE
- ☐ OTHER _____

PLEASE ANSWER THE FOLLOWING QUESTION 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.

YOUNGER THAN		TRUE AGE		OLDER THAN
1	**2**	**3**	**4**	**5**

DO YOU SMOKE? **YES** **NO**

FACIAL SURGERY

A. Have you had laser resurfacing or facial plastic surgery in the past 3 months?
YES **NO**

B. Are you planning to have facial resurfacing soon?
YES **NO**

C. Are you planning to have other facial plastic surgery soon?
YES **NO**

WHAT DO YOU LIKE LEAST ABOUT YOUR SKIN? _____

_____

HOW DID YOU HEAR ABOUT US?

My Physician: (Full Name) _____

Magazine: _____

A friend or family member: _____

The Internet (website): _____

Seminar: (Specify seminar &date) _____

Other: _____

APPROVAL TO CONTACT YOU: YES NO

APPROVAL TO SEND YOU PRODUCT AND SERVICE INFORMATION (INCLUDING SPECIAL OFFERS):

YES NO

Best phone number to contact you: _____

Email Address: _____

Patient Signature: _____ Date _____

FOR OFFICE USE ONLY

PHYSICIAN (PROVIDER) NAME: _____

COMPLETED BY: _____

FOLLOW- UP CALL: _____

SEMINAR PARTICIPATION: _____

FREE CONSULTATION: _____

PROCEDURE SCHEDULED: _____

PROCEDURE COMPLETED: _____

COMMENTS: _____

_____