Premier Plastic Surgery Center

Facial Rejuvenation Questionnaire

NAME_____DATE_____/_____/_____

Do you think you've had excessive sun exposure in your life? Yes No
Have you routinely used facial sunscreen since childhood? Yes No
Do you use sunscreen routinely now? Yes No
Have you ever had a skin cancer? Yes No If so, where?_____
Has your hairline been receding? Yes No If so, for how long?_____
Are you concerned with forehead wrinkles? Yes No
Do you feel that your eyebrows have dropped? Yes No
Do you think your upper eyelids make you look tired? Yes No
Do you think your lower eyelids make you look tired? Yes No
Are you bothered by increased pigment in your lower eyelids? Yes No
Are you bothered by wrinkles around your eyes? Yes No
Do you think your upper eyelids are too puffy? Yes No
Do you think your lower eyelids are too puffy? Yes No
Do you suffer from dry eyes? Yes No If so, how often do you use eye drops?_____
Do you were eyeglasses? Yes No If so, to read or drive a car?_____
Do you wear contact lenses? Yes No If so, how many hours per day?_____
Do you feel that your cheeks have lost volume? Yes No
Do you feel that your whole face has dropped? Yes No
Are you bothered by the lines (folds) from your nose down to your mouth? Yes No
Are you bothered by wrinkles around your mouth? Yes No
Would you like fuller lips? Yes No
Are you bothered by the lines (folds) from the corners of your mouth down toward your jaw? Yes No
Are you bothered by your jowls? Yes No
Are you bothered by the appearance of your neck? Yes No
Do you think you look older than your stated age? Yes No
When you look at your face, what area(s) bother you the most?_____
Have you ever had Botox injections? Yes No
Ever have injectable fillers or fat grafts into your face? Yes No
Any prior facial surgery? Yes No If so, what? _____
Have you discussed facial rejuvenation with any other doctors? Yes No
Ever smoke?_____How much?_____How many years?_____Quit?_____

_____OFFICE USE ONLY BELOW THIS LINE_____

Exam Date_____/_____/20_____ Old pics Y N