


# J. Kevin Duplechain, MD, FACS



**PLASTIC AND RECONSTRUCTIVE  
SURGERY & SKINCARE**

Cosmetic Interest Questionnaire	
Name: _____	
Address: _____	
Telephone: _____	
Please e-mail me information on special offers and events!  Yes _____ No _____	How did you hear about us? (circle one below)
E-Mail Address: _____	Magazine      Phonebook      Sign out Front Employee      Family _____ Friend _____
Birth Date: _____	Physician Referral, Who: _____ Other, Please Specify: _____

<p><b>These are the areas of concern for me:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fine Lines and wrinkles</li> <li><input type="checkbox"/> Wrinkles / Lines around nose and mouth</li> <li><input type="checkbox"/> Length / Thickness of eyelashes</li> <li><input type="checkbox"/> Texture of skin / Pore Size</li> <li><input type="checkbox"/> Facial Veins</li> <li><input type="checkbox"/> Spider Vein Treatment</li> <li><input type="checkbox"/> Age Spots / Liver Spots (skin blemishes)</li> <li><input type="checkbox"/> Birthmarks</li> <li><input type="checkbox"/> Skin Pigmentation</li> <li><input type="checkbox"/> Acne</li> <li><input type="checkbox"/> Unwanted Hair (Facial or Body)</li> <li><input type="checkbox"/> Dark circles under eyes</li> <li><input type="checkbox"/> Freckles / Sun Damage</li> <li><input type="checkbox"/> Dryness</li> <li><input type="checkbox"/> Other _____</li> </ul>	<p><b>Ranking of concerns:</b></p> <ol style="list-style-type: none"> <li>1. _____</li> <li>2. _____</li> <li>3. _____</li> <li>4. _____</li> <li>5. _____</li> <li>6. _____</li> <li>7. _____</li> </ol> <div style="text-align: center;">  <p><i>Please feel free to mark areas of concern on facial diagram.</i></p> </div>																
<p><b>These are treatments I am interested in:</b></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Facelift</td> <td><input type="checkbox"/> Latisse</td> </tr> <tr> <td><input type="checkbox"/> Eyelid Surgery</td> <td><input type="checkbox"/> Browlift</td> </tr> <tr> <td><input type="checkbox"/> Rhinoplasty</td> <td><input type="checkbox"/> Injectables</td> </tr> <tr> <td><input type="checkbox"/> Liposuction</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Body Contouring</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Rejuvenation</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Facials and eye treatments</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Skin Care Products</td> <td></td> </tr> </table>	<input type="checkbox"/> Facelift	<input type="checkbox"/> Latisse	<input type="checkbox"/> Eyelid Surgery	<input type="checkbox"/> Browlift	<input type="checkbox"/> Rhinoplasty	<input type="checkbox"/> Injectables	<input type="checkbox"/> Liposuction		<input type="checkbox"/> Body Contouring		<input type="checkbox"/> Rejuvenation		<input type="checkbox"/> Facials and eye treatments		<input type="checkbox"/> Skin Care Products		<p><b>Other Comments:</b></p>   
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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	

Signature: \_\_\_\_\_