



Robert J. Grieshaber, MD
Board Certified Dermatologist

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COSMETIC INTEREST QUESTIONNAIRE (OPTIONAL)

Patient Name: _____

What is your reason for your visit today? _____

Date : _____

At Grieshaber Dermatology, we care to provide high quality services personalized for your unique needs. Are there any additional services or topics that you would like to learn about? Please check all that apply.

| | | |
|--|--|---|
| <input type="checkbox"/> Skin care advice <input type="checkbox"/> Skin care products <input type="checkbox"/> Injectable Treatments <input type="checkbox"/> Facial fine lines/wrinkles <input type="checkbox"/> Thin lips <input type="checkbox"/> Blotchy skin | <input type="checkbox"/> Chemical peel <input type="checkbox"/> Make up <input type="checkbox"/> Facial veins <input type="checkbox"/> Facial redness <input type="checkbox"/> Brown spots/age spots/freckles <input type="checkbox"/> Drooping brow <input type="checkbox"/> Drooping eyelids | <input type="checkbox"/> Facial fullness/drooping <input type="checkbox"/> Mole removal <input type="checkbox"/> Scar revision <input type="checkbox"/> Leg veins <input type="checkbox"/> Unwanted Hair <input type="checkbox"/> Length/Fullness of Eyelashes <input type="checkbox"/> Stretch Marks |
| Other: _____ | | |

Are you interested in meeting one of our Medical Estheticians for a complimentary skin care consultation to create a Personal Treatment Plan designed to meet your cosmetic need?

- Yes
- No, thank you

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

I'm not interested in any additional services provided at this time

Patient Signature: _____ **Date:** _____

Make sure to like us on Facebook to keep up with our latest special offers