



**Center for Smile Enhancement . Michael S. Sudit, D.D.S. LLC**

10500 Wayzata Blvd. Minnetonka, MN 55305

**(952) 593-9310**

## **Facial Aesthetic Assessment Questionnaire**

### **Contact Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Mobile phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Please indicate your preferred method of contact: \_\_\_\_\_

### **Facial Aesthetic Assessment Information**

#### **Skin Type:**

Oily \_\_\_ Normal \_\_\_ Dry \_\_\_ Sensitive \_\_\_ Combination \_\_\_

#### **Cosmetic History:**

Facial surgery in the past year? Y N If yes, what type? \_\_\_\_\_ Date \_\_\_\_\_

Collagen/Dermal fillers (Juvederm, Restylane etc)? Y N Date of last treatment \_\_\_\_\_

Botox injections? Y N If yes, where on face? \_\_\_\_\_ Date \_\_\_\_\_

Peel treatment in the past year? Y N When? \_\_\_\_\_ Type? \_\_\_\_\_

Facial treatment in the past year? Y N When? \_\_\_\_\_ Type? \_\_\_\_\_

Were you pleased with the outcome? Y N

If no, in what way were you dissatisfied? \_\_\_\_\_

**Skin Care History:**

(please indicate which of the following products you currently use)

Cleanser \_\_\_ Toner \_\_\_ Moisturizer \_\_\_ Sunscreen \_\_\_

Skin lightener \_\_\_ Anti-Aging Formula \_\_\_ Facial Scrubs \_\_\_

Alpha Hydroxy Acids \_\_\_ Retin-A (%) \_\_\_ Self Tanning Creams \_\_\_

Topical Rx \_\_\_ Accutane \_\_\_

**The best results will be achieved through combination therapy by using multiple products and procedures. Please let us know which of the following are of interest to you. Please check all that apply.**

|                                   |     |                             |     |
|-----------------------------------|-----|-----------------------------|-----|
| Facial lines/wrinkles             | ___ | Marionette lines            | ___ |
| Thin lips                         | ___ | Blotchy skin                | ___ |
| Skin texture                      | ___ | Dry or oily skin            | ___ |
| Nose to mouth lines               | ___ | Dark circles under eyes     | ___ |
| Brown spots/age spots/freckles    | ___ | Acne                        | ___ |
| Sun protection                    | ___ | Chemical peel               | ___ |
| Neck wrinkles                     | ___ | Frown lines (“11’s)         | ___ |
| Forehead lines                    | ___ | Crow’s feet or squint lines | ___ |
| Perioral rhytids (smoker’s lines) | ___ | Gummy smile                 | ___ |

**Would you like to receive e-mails from our office about special events, opportunities and savings?    Y    N**

**If our office hosted future events to inform patients about cosmetic procedures, would you be interested in attending?    Y    N**

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**THANK YOU!**