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Pre Cosmetic Consultation Questionnaire

Name: Date of Birth:

Telephone Number: Email Address:

What are your primary cosmetic concerns?

What is your treatment budget?

Do you have a specific event for which you are preparing? ☐ Yes ☐ No ☐ Maybe

If yes, please specify:

Do you have any allergies to medications or skincare products? ☐ Yes ☐ No

If yes, please list product and reaction:

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list them *(include over the counter medications and herbal supplements)*:

Do you have any medical conditions that we should be aware of? ☐ Yes ☐ No

If yes, please describe:

Have you had any cosmetic treatments in the past? ☐ Yes ☐ No

If yes, please specify:

Please list any specific treatments you would like more information on: