



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

	Yes	No	This Is Why I Am Here
Do you feel a lump in your throat when swallowing?			
Do you feel a burning in your chest after eating?			
Do you have problems swallowing?			
Do you wake up in the morning with a lot of mucus in your throat?			
Do you ever get hoarse? Always.....Sometimes.....Never			
Do you have problems hearing?			
Do you ever get dizzy or off-balance?			
Do you have ringing or buzzing in your ears?			
Do you snore?			
Do you feel sleepy or tired during the day?			
Do you have trouble sleeping at night?			
Do you have any face or skin growths or problems you want us to take a look at?			
Do you have allergies?			
Do you often get colds or sinus infections?			
Do you have problems breathing through your nose?			

If you are interested in receiving information on any of the following please continue.

### Carolina Cosmetics

- |  |  |
|--|--|
| <input type="checkbox"/> Hair Transplantation    | <input type="checkbox"/> Laser Treatments              |
| <input type="checkbox"/> BOTOX Cosmetic          | <input type="checkbox"/> Facial Plastic Surgery        |
| <input type="checkbox"/> Juvederm Injectable Gel | <input type="checkbox"/> Skin Care                     |
| <input type="checkbox"/> Restylane / Radiesse    | <input type="checkbox"/> Rosacea                       |
| <input type="checkbox"/> Skin Rejuvenation       | <input type="checkbox"/> Birthmarks / Scars            |
| <input type="checkbox"/> Microdermabrasion       | <input type="checkbox"/> Liver Spots / Age Spots       |
| <input type="checkbox"/> Acne                    | <input type="checkbox"/> Hair Removal                  |
| <input type="checkbox"/> Chemical Peels          | <input type="checkbox"/> Vein Treatment / Vein Removal |

How would you like to be contacted?

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

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_