

ASDS 2014 Survey on Dermatologic Surgery Procedures

Member ID (required) _____

Please indicate the number of dermatologists for which you are reporting data _____
Estimate the percentage of time each week you spend doing these procedure types: Oncologic/reconstructive _____% dermatology Cosmetic _____% dermatology Medical / therapeutic _____% dermatology (not skin cancer) _____%
SKIN CANCER – Do you offer treatments? Yes _____ No _____ If yes, please provide totals.
If YES, total skin cancer treatment procedures by type: (Do not include biopsies in your totals) Melanoma _____ Non-melanoma _____
INJECTABLE NEUROMODULATORS – Do you offer? Yes _____ No _____ If yes, please provide totals.
If YES, total neuromodulator procedures: Botox _____ Dysport _____ Xeomin _____
Estimate gender of patients: Male _____% Female _____%
Estimate, by percentage, the age range that best describes your neuromodulator patients: ≤30 _____% 31-35 _____% 36-40 _____% 41-45 _____% 46-50 _____% 51-55 _____% >55 _____%
SOFT-TISSUE FILLERS – Do you offer treatments? Yes _____ No _____ If yes, please provide totals.
Totals: Belotero _____ Juvederm _____ Radiesse _____ Restylane/Perlane _____ Sculptra _____ Voluma _____
Estimate gender of patients: Male _____% Female _____%
Estimate, by percentage, the age range that best describes your soft-tissue filler patients: ≤30 _____% 31-35 _____% 36-40 _____% 41-45 _____% 46-50 _____% 51-55 _____% >55 _____%
BODY SCULPTING – Do you offer treatments? Yes _____ No _____ If yes, please provide totals.
Cryolipolysis _____ Laserlipolysis _____ Tumescant liposuction _____ Radiofrequency _____ Other non-invasive treatment of fat and cellulite _____
LASER HAIR REMOVAL – Do you offer treatments? Yes _____ No _____ If yes, please provide totals.
If YES, total laser hair removal treatment sessions _____
LASER / LIGHT / ENERGY-BASED PROCEDURES – Do you offer? Yes _____ No _____ If yes, provide totals.
If YES, totals for: Acne scars _____ Surgical & traumatic scars _____ Laser resurfacing _____ Facial redness and/or vessels _____ Photo rejuvenation/wrinkles _____ Lentiginosities _____ Tattoos _____ Birthmarks _____ Photodynamic therapy _____ Tissue tightening _____
VEINS TREATMENTS / SCLEROTHERAPY – Do you offer? Yes _____ No _____ If yes, provide totals.
If YES, total vein treatments _____
CHEMICAL PEELS – Do you offer treatments? Yes _____ No _____ If yes, please provide totals.
If YES, total chemical peel treatments _____
HAIR TRANSPLANTATIONS – Do you offer treatments? Yes _____ No _____ If yes, provide totals.
If YES, total hair transplantation treatments _____

Please fax this completed form to 847-956-0999 by **Friday, Feb. 6.**