PATIENT CONCERNS

NAME:_____ DATE:_____

EMAIL:_____ PHONE:_____

Forehead Lines/Frown Lines?
YES NO

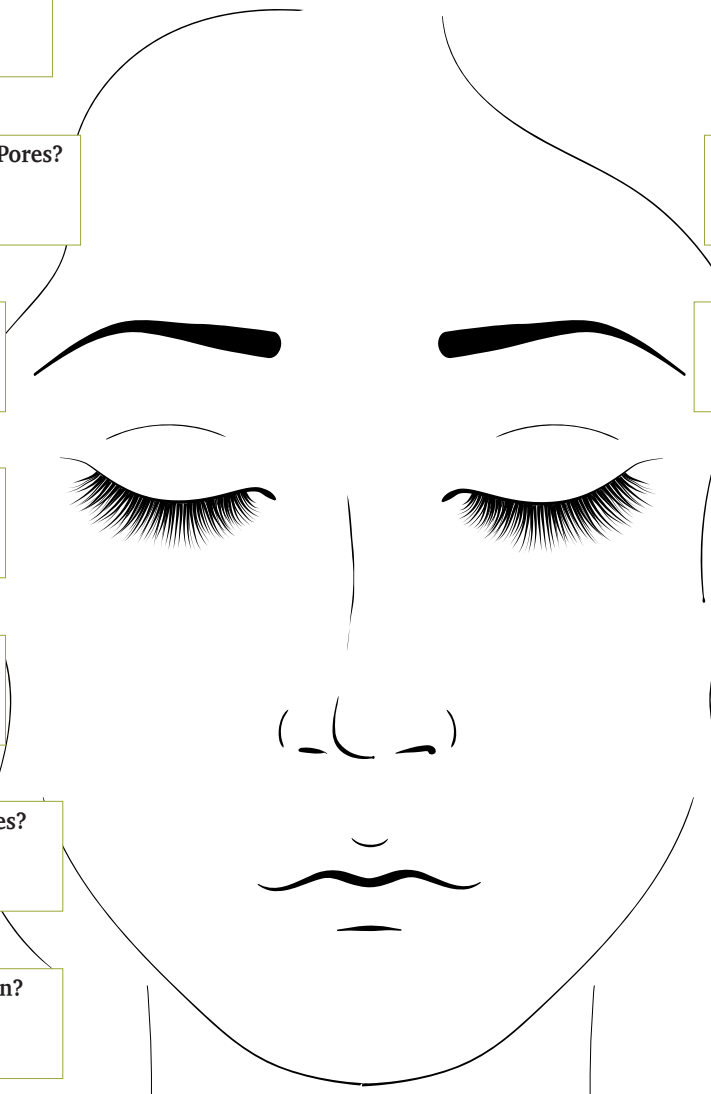
Crow's Feet?
YES NO

Improve Texture of Skin/Large Pores?
YES NO

Under Eye Circles/Lines/Bags?
YES NO

Facial Volume Loss?
YES NO

Thin, Short, or Lightened Lashes?
YES NO



Nose-to-Mouth Lines?
YES NO

Brown Spots/Freckles?
YES NO

Lips/Volume Loss?
YES NO

Broken Blood Vessels?
YES NO

Lip Lines/Lipstick Bleed Lines?
YES NO

Acne Scarring/Facial Scars?
YES NO

Neck and Chest Discoloration?
YES NO

Red Spots/Flushing?
YES NO

Texture/Saggy Skin?
YES NO

Are you interested in Skin Care?
YES NO

Please add any additional concerns not listed above

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