**Please let us know the primary concern that brought you into our office today?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Lines around my eyes |  | Red, blotchy skin |  | Brown spots on face or body |
|  | Lines between my eyes (angry look) |  | Excess skin above eyes |  | Droopy brows |
|  | Lines on forehead |  | Thin face/no cheeks |  | Frown or down turned mouth "sad" |
|  | Lines under eyes |  | Dimpled chin |  | Broken blood vessels on face |
|  | Puffy eyes |  | Crepe-y skin |  | Wrinkled neck |
|  | Thins lips |  | Sunken-in eyes |  | Crease- Nose to corner of mouth |
|  | Dry skin |  | Skin texture |  | Excess skin under neck |
|  | Oily skin |  | Unwanted hair |  | Other: |
|  | Looking tired |  | Aging hands |  |  |
|  | Hair loss |  | Wide lower face |  |  |

Our goal is to respond to all our patient's needs and to provide the highest quality care. In order to provide the information and services you desire, we ask that you please share any other concerns you may have by completing the section below:

**Service Interest**Check the services you are interested in learning more about:

**□ Neurotoxin (botox) □ Dermal Fillers (Juvederm) □ Kybella □ Chemical Peel □ Micro-needling**

**□ Facials □ Derma planning□ PRP Hair Rejuvenation □ Laser Hair Removal □ IPL (Intense Pulsed Light)
□ Scar Revision □ Blepharoplasty (Eyelid Surgery) □ Cheek Implants □ Chin Implant □ Rhinoplasty (Nose Job)**

**□ Otoplasty (Ear Pin Back Surgery) □ Ear Lobe Repair □ Buccal Fat Pad Reduction (Facial Slimming)**

**□ Brow Lift □ Neck Liposuction □ Lower Face & Neck Lift □ Fat Transfer**

**□ Other:**

# **Skincare Regimen**

Please provide some information about your current skin regimen. Please check all that apply, including the
name of the product(s) you use.

**□** Cleaner **□** Moisturizer **□** Toner **□** Sunscreen/Sunblock
**□** Treatments (Retin A, Vitamin C, Bleaching Cream, etc):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
**Printed Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_