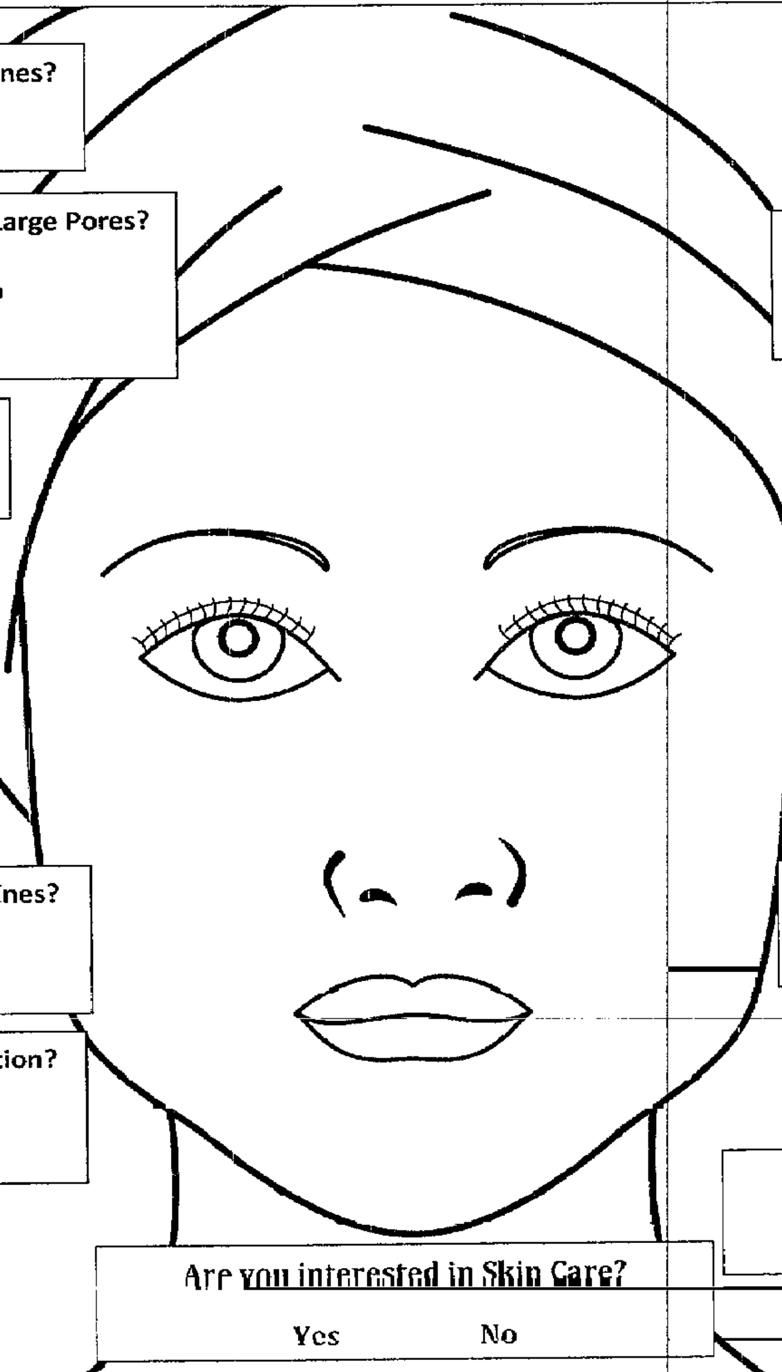
Patient Concerns

NAME:______________________ DATE:______________

EMAIL:______________________ PHONE:______________



Forehead Lines/ Frown Lines?
Yes No

Improve Texture of Skin/Large Pores?
Yes No

Facial Volume Loss?
Yes No

Nose-to-Mouth Lines?
Yes No

Lips/Volume Loss?
Yes No

Lip Lines/Lipstick Bleed Lines?
Yes No

Neck and Chest Discoloration?
Yes No

Crow's Feet?
Yes No

Under Eye Circles/Lines/Bags?
Yes No

Thin, short or lightened Lashes?
Yes No

Brown Spots/Freckles?
Yes No

Broken Blood Vessels?
Yes No

Acne Scaring/Facial Scars?
Yes No

Red Spots/Flushing?
Yes No

Texture/Saggy Skin?
Yes No

Are you interested in Skin Care?
Yes No

Please any additional concerns not listed above

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