

## Cosmetic Survey

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

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

DOB: \_\_\_\_\_

Email \_\_\_\_\_

### I am interested in the following:

#### Wrinkles

- Around Eyes
- Around Mouth
- Forehead
- Between Brow
- Other \_\_\_\_\_

#### Brown Spots

- Face
- Neck
- Chest
- Hands
- Arms

#### Broken Veins

- Face
- Neck
- Chest
- Legs

#### Red/Ruddy Skin

- Face
- Neck
- Chest
- Other \_\_\_\_\_

#### Saggy/Loose Skin

- Face
- Neck
- Eyes

#### NeoGraft/Hair Loss

- Thinning Hair
- Balding

#### Volume Defect

- Lips
- Under eyes
- Hands

#### Unwanted Fat

- Chin
- Stomach
- Arms
- Thighs
- Back
- Hips
- Buttocks

#### Skin Texture/Tone

- Rough
- Dry
- Oily
- Blotchy

#### Acne

- Blackheads
- Pustules
- Whiteheads
- Scarring

#### Unwanted Hair

- Face
- Body

Botox™ Cosmetic

Restylane

Photo-rejuvenation

Micro-Dermabrasion

Threadlift™

Safelift™

Chemical Peels

Tumescent Liposuction

Proper Skin Regimen

Puffy Eyes

Dark Circles

#### What objections might you have to addressing any of these issues?

- Cost
- Time
- Fear of Pain
- Other \_\_\_\_\_

#### If you would like to receive information on how we can help with these issues, please choose which contact method you prefer?

- US Mail
- Email \_\_\_\_\_
- Phone \_\_\_\_\_
- Free Consultation
- I do not wish to be contacted.