

## Patient Self-Assessment

Name: \_\_\_\_\_

Date: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Preferred method of contact? \_\_\_\_\_

1. What is the main reason you came in for this consultation?

---

---

2. What aesthetic treatments and procedures, if any, have you had in the past?

---

---

3. If you have previously had any aesthetic treatments or procedures, were you pleased with the results?

Yes       No      If no, in what way were you dissatisfied?

---

---

4. Do you have any concern and/or allergies with aesthetic treatments?

Yes       No      If yes, identify them below:

---

---

## Aesthetic Products, Treatment, and Procedures

Name \_\_\_\_\_

Date \_\_\_\_\_

Please let us know which of the following aesthetic products, treatments, and procedures interest you. Please check all that apply:

- |  |  |
|--|--|
| <input type="checkbox"/> Acne/Scarring Treatment<br><input type="checkbox"/> AHA/Glycolic Peel<br><input type="checkbox"/> Body Contouring<br><input type="checkbox"/> Cellulite Treatment<br><input type="checkbox"/> Chemical Peels<br><input type="checkbox"/> Dermal Infusion<br><input type="checkbox"/> Facial Plastic Surgery List: _____<br><input type="checkbox"/> Facial Vein Correction<br><input type="checkbox"/> Filler<br><input type="checkbox"/> Laser Hair Removal<br><input type="checkbox"/> Hair Restoration<br><input type="checkbox"/> Vaginal Rejuvenation -Sexual Dysfunction, Laxity, SUI | <input type="checkbox"/> Lip Enhancement<br><input type="checkbox"/> Liver Spot/Age Spot Correction<br><input type="checkbox"/> Mechanical Exfoliation<br><input type="checkbox"/> Professional Skin Care Products<br><input type="checkbox"/> Intense Pulsed Light Therapies (Photofacial IPL)<br><input type="checkbox"/> Radio Frequency Assisted Liposuction<br><input type="checkbox"/> Skin Tightening<br><input type="checkbox"/> Skin Rejuvenation<br><input type="checkbox"/> Sunscreen Advice<br><input type="checkbox"/> Wrinkle Blocker<br><input type="checkbox"/> Excessive Sweating<br><input type="checkbox"/> Laser Resurfacing |
|--|--|

### Skin Concerns:

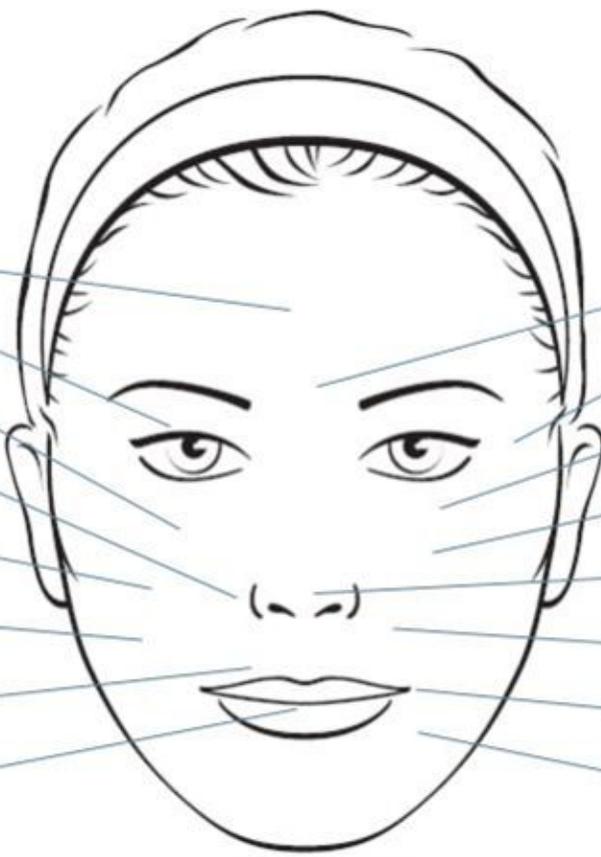
- |  |  |
|--|--|
| Do you have any concerns with the appearance of your skin? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you want to learn more about home skin care?            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have issues with wrinkles or fine lines?            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any known issues with sun damage or age spots? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any issues with large pores or skin texture?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any concerns with facial redness?              | <input type="checkbox"/> Yes <input type="checkbox"/> No |

## Facial Anatomic Representation

Name \_\_\_\_\_

Date \_\_\_\_\_

With respect to facial aesthetics, please highlight those areas of the face that bother or trouble you. In the boxes provided, please rate these areas on a scale of 1 to 5 (1 being less bothersome, 5 being most bothersome). Feel free to draw on the chart to identify any other facial concerns.



Forehead

Drooping Eyelids

Freckles and pigmentation

Blood vessels

Volume Loss

Scarring

Vertical lips lines (Smokers' lines)

Lips: Definition and/or Fullness

Frown lines

Crow's feet

Dark Circles

Acne

Nose

Nasolabial folds (Nose-to-mouth lines)

Oral commissures (Corner-of-the-mouth lines)

Marionette lines (Mouth-to-chin lines)

Larger pores, poor skin texture, and fine lines

Jowls, Neck, Other  
Please list: \_\_\_\_\_