HOW CAN WE HELP YOU WITH WHAT BOTHERS YOU MOST ABOUT YOUR SKIN?

Name: _____**Date of Birth**: _____**Today's Date**: _____

Email:_____ **Phone #** _____

I am bothered by: (please check all that apply)

- ☐ **Unwanted hair growth on my face/body**
- ☐ **Redness of my face**
- ☐ **Fine lines & wrinkles on my face**
- ☐ **"Crow's feet"**
- ☐ **Thin lips**
- ☐ **Wrinkles around my mouth**
- ☐ **"Hollow" cheeks**
- ☐ **Red veins on my face**
- ☐ **Red spots on my face/body**
- ☐ **Deep lines on my cheeks/ "jowls"**
- ☐ **Dark spots on my face/chest/hands**
- ☐ **Acne scars**
- ☐ **Wrinkles around eyes**
- ☐ **Preventative Skin care**
- ☐ **Moles that I would like checked**

Procedures or products of interest to you (please check all that apply)

- ☐ **BOTOX & DYSPORT**
- ☐ **Dermal Fillers (i.e. Juvederm/Restylane. Radiesse)**
- ☐ **Facial Volumization (Sculptra)**
- ☐ **Clarisonic Skincare Brush**
- ☐ **Obagi**
- ☐ **IPL**
- ☐ **Fraxel**
- ☐ **Laser hair removal**
- ☐ **Microdermabrasion**
- ☐ **Chemical peel**
- ☐ **Laser vein removal**
- ☐ **Sclerotherapy**

Treatment Goals: Instant Gradual (subtle change) Short-term Long-lasting

Are you pregnant trying to become pregnant or lactating? **Yes No**
Do you get cold sores or fever blisters? **Yes No**
Do you use a tanning bed? **Yes No**
Do you use sunless tanning lotions? **Yes No**
Do you use sunscreen? **Yes No**
Have you ever used a retinoid cream on your face? (Retin-A, Differin, etc.)_____
Have you ever had facial cosmetic surgery?_____

How did you hear about us?
My physician (full name) _____Other:_____
A friend or family member (name) _____Internet_____