Aesthetic Patient Self-Assessment

Please complete this questionnaire to help us better understand your history, preferences, and concerns with respect to aesthetic treatments and procedures. Your responses will help us identify and recommend the most appropriate treatments and procedures for you:

Please provide us with your email address for notifications of specials, promotions, and upcoming events:

Email: ________________________________

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 outcome?

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

__________________________________________________________________________

__________________________________________________________________________

4. Do you have any concerns about aesthetic treatments or procedures?  ☐ Yes  ☐ No

If yes, identify your concerns:

__________________________________________________________________________

__________________________________________________________________________
Aesthetic Products, Treatments, and Procedures

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

☐ Eye Brow Lift
☐ Eyelid Lift
☐ Blepharoplasty: Upper
☐ Blepharoplasty: Lower
☐ Botulinum Toxin Type A
☐ Lip Enhancement/Reduction
☐ Chemical Peels
☐ Neck Liposuction
☐ Dermal Fillers
☐ Facial Implants
☐ Facial Plastic Surgery
☐ Rhinoplasty
☐ Professional Skin Care Products
☐ Skin Rejuvenation
☐ Laser Resurfacing
☐ Topical Wrinkle Treatment
☐ Sunscreen Advice
☐ Fat Transfer
☐ Face Lift

☐ Other (please list):

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
Facial Anatomic Representation

With respect to facial aesthetics, please highlight those areas of the face that bother or trouble you.

In the boxes provided, please mark an ‘X’ in the areas that you would to discuss and/or have treated.

Feel free to draw on the chart to identify any other facial concerns.
Skin Concerns

Do you have any concerns with the appearance of your skin? ............... □ Yes □ No
Do you want to learn more about at home skin care? ......................... □ Yes □ No
Do you have any issues with wrinkles or fine lines? ......................... □ Yes □ No
Do you have any concern with redness? ..................................... □ Yes □ No
Do you have any issues with sun damage or age spots? ..................... □ Yes □ No
Do you have any issues with large pores or skin texture? ................. □ Yes □ No