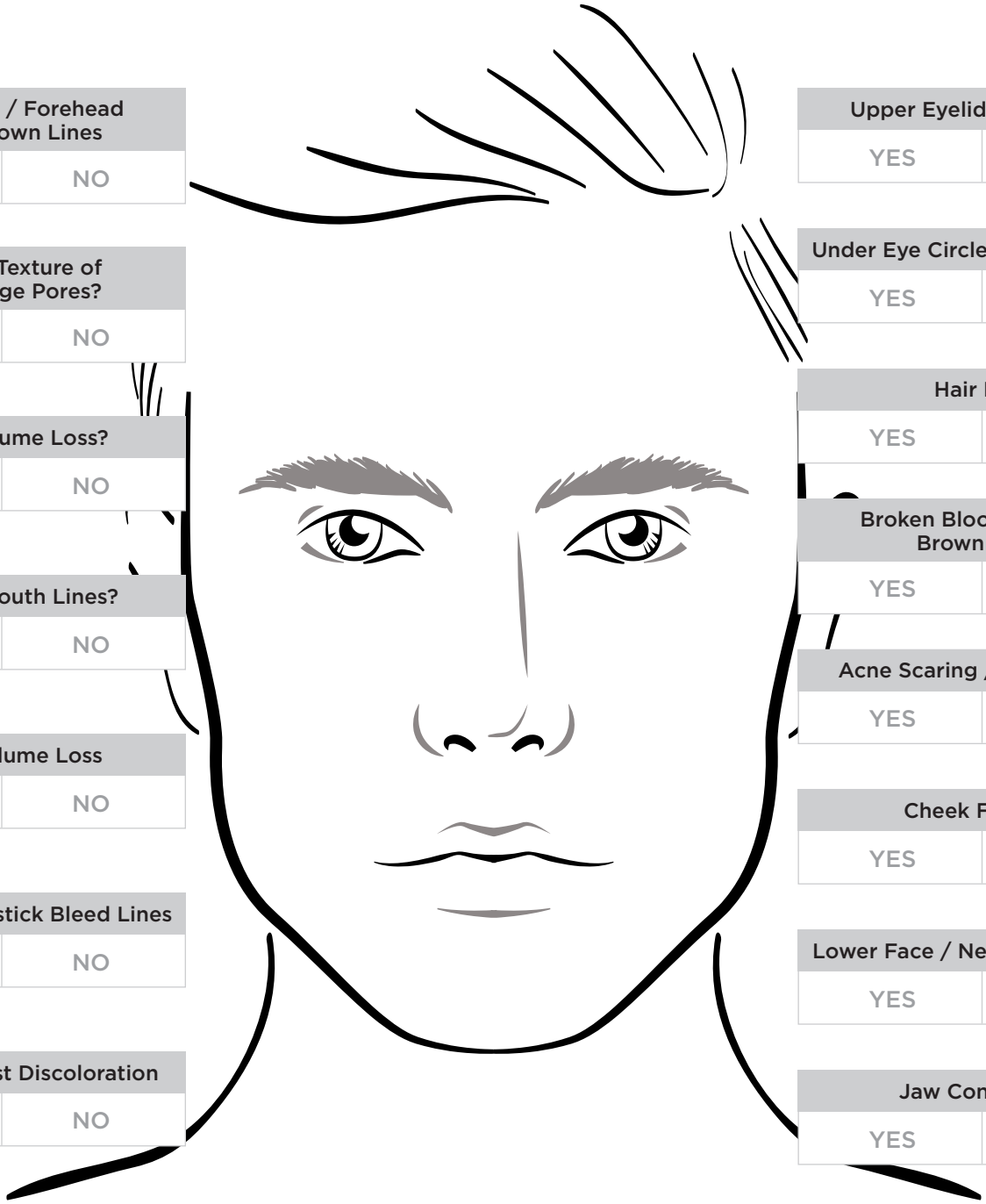
# PATIENT QUESTIONNAIRE

| Name: | Date: |
|---|---|



| Crows Feet / 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 |

| Lips Lines / Lipstick Bleed Lines | |
|---|---|
| YES | NO |

| Neck and Chest Discoloration | |
|---|---|
| YES | NO |

| Are you interested in skin care? | |
|---|---|
| YES | NO |

| Double Chin / Neck Fullness? | |
|---|---|
| YES | NO |

| Upper Eyelid Skin Excess | |
|---|---|
| YES | NO |

| Under Eye Circles / Lines / Bags | |
|---|---|
| YES | NO |

| Hair Loss | |
|---|---|
| YES | NO |

| Broken Blood Vessels / Brown spots | |
|---|---|
| YES | NO |

| Acne Scaring / Facial Scars | |
|---|---|
| YES | NO |

| Cheek Fullness | |
|---|---|
| YES | NO |

| Lower Face / Neck / Saggy Skin | |
|---|---|
| YES | NO |

| Jaw Contouring | |
|---|---|
| YES | NO |

| Other | |
|---|---|
| YES | NO |

Please add any additional concerns not listed: _____

MADNANIFACIALPLASTICS