aboutface SKIN CARE MEDICAL AESTHETICS

Patient Interest Questionnaire

Name: _____ **Age:** _____ **Date:** ____ /____ /____

Please indicate any areas of concern for you. Check all that apply.

☐ Forehead Lines

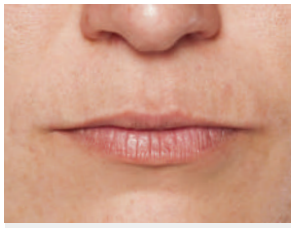
☐ Frown Lines

☐ Crow's Feet Lines

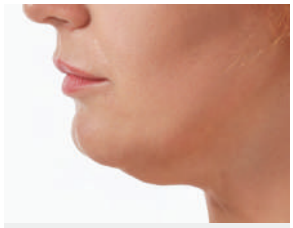
☐ Fllattened or Sunken Cheeks

☐ Lines and Wrinkles around nose and mouth

☐ Smoker's Lines

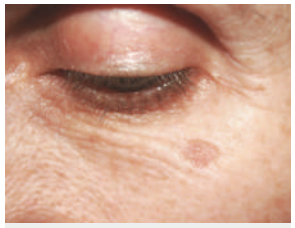


☐ Thin Lips

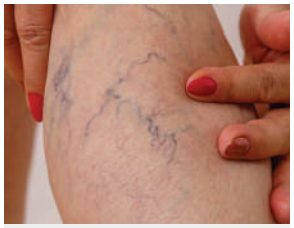


☐ Double Chin

☐ Thinning or Inadequate Lashes



☐ Skin Appearance and Texture

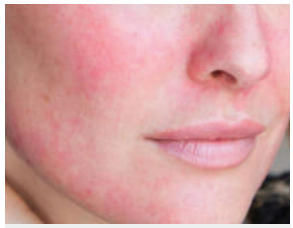


☐ Spider Veins

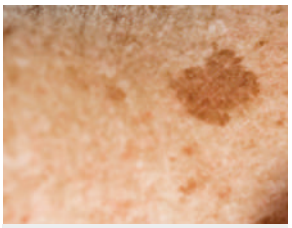
☐ Fat Pockets

☐ Thinning Hair

☐ Excessive Sweating

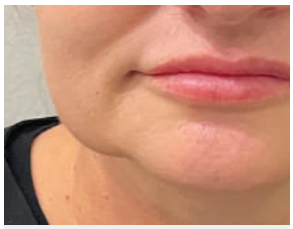


☐ Rosacea/ Broken Capillaries

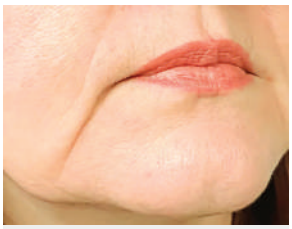


☐ Brown Spots

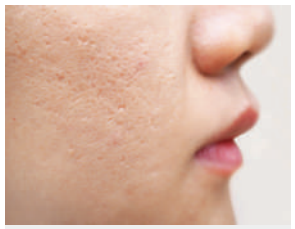
☐ Lack of Energy



☐ Jowls



☐ Marionette Lines



☐ Acne Scarring

Share how you see yourself.

I feel like I look:
Check all that apply

☐ Sad ☐ Less Lively ☐ Pained
☐ Angry ☐ Fearful ☐ Less Derisable
☐ Tired ☐ Saggy ☐ Older Than I Feel

☐ Other _____

Be sure to bring this to your aesthetic specialist for your assessment. Next Appointment Date:____/____/____