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Patient Concerns Questionnaire

Patient Name: _____ Date: _____

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply.

Skin Care advice	Facial Veins	Leg Veins
Skin Care products	Facial fine lines/wrinkles	Breast size
Facial Fullness/Drooping	Brown/age spots/freckles	Bikini Tummy Tuck
Facial Injectables/Fillers	Tired, dull skin	Body Contouring
Facial Fat Transfer	Length/Fullness of eyelashes	Abdominal Area
Thin Lips	Rough texture of the Skin	Hips
Facial Veins	Facial/peel treatments	Thighs
Blotchy skin	Acne	Neck/Jawline
Facial Redness	Unwanted Hair	Weight Loss
		Vaginal Concerns

Other _____

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