Patient Concerns Questionnaire

Silk Touch
MedSpa, Laser & Lipo

Pt:

Date of birth:

2019.08 - 77709

Today's Date: _____

Please select any concerns you have or treatments you would like to discuss:

FACE & SKIN

- ☐ Facial Fullness/Drooping
- ☐ Facial Injectables/Fillers
- ☐ Fine lines/wrinkles
- ☐ Thin Lips
- ☐ Hollow cheeks
- ☐ Facial Veins
- ☐ Facial Redness or Blotchy Skin
- ☐ Brown/age spots/freckles
- ☐ Tired, dull skin
- ☐ Facial/Peel treatments
- ☐ Acne
- ☐ Enlarged Pores
- ☐ Dry or Oily Skin
- ☐ Length/Fullness of Eyelashes
- ☐ Skin Care Advice (general)
- ☐ Rough Texture of the Skin
- ☐ Unwanted Hair
- ☐ Under eye Bags / Dark Circles
- ☐ Scarring

BODY

- ☐ Unwanted Hair
- ☐ Body Contouring/Liposuction
  - ☐ Abdominal Area
  - ☐ Hips
  - ☐ Thighs
  - ☐ Neck/Jawline
  - ☐ Calves
  - ☐ Ankles
  - ☐ Arms
- ☐ Under Chin Fat Reduction/Non-Surgical
- ☐ Skin Tightening
- ☐ Excessive Sweating
- ☐ Knee Skin Tightening
- ☐ Vaginal Rejuvenation
- ☐ Hair Loss

Other Concerns:

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