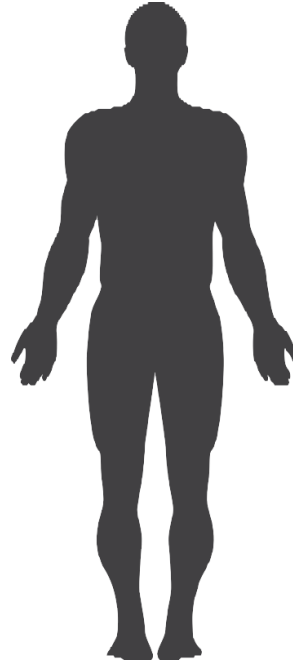
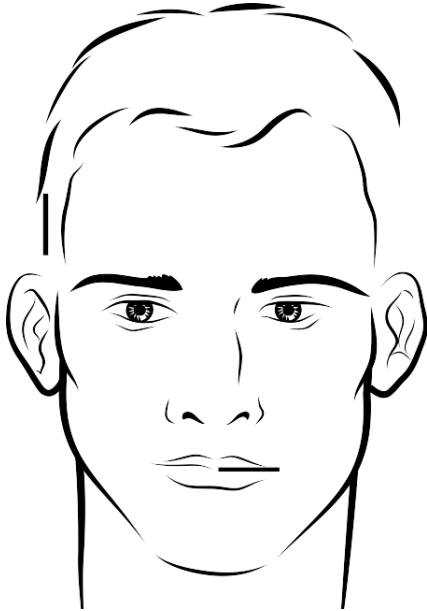


Name:	What is the reason for your visit today?
Date:	

Areas of concern for me:

Please check all that apply and circle the areas on the diagram.



<u>SKIN</u>	<u>BODY</u>	<u>MEDICAL</u>
<input type="checkbox"/> Fine lines, wrinkles <input type="checkbox"/> Frown lines <input type="checkbox"/> Deep lines around nose and mouth <input type="checkbox"/> Texture of skin <input type="checkbox"/> Pigmentation <input type="checkbox"/> Age spots, sun spots <input type="checkbox"/> Large pores <input type="checkbox"/> Acne/Acne scars <input type="checkbox"/> Sagging loose skin <input type="checkbox"/> Crow's Feet <input type="checkbox"/> Unwanted hair <input type="checkbox"/> Redness, Rosacea <input type="checkbox"/> Dry, sensitive skin <input type="checkbox"/> Enlarged blood vessels <input type="checkbox"/> Other	<input type="checkbox"/> Unwanted hair <input type="checkbox"/> Skin discoloration <input type="checkbox"/> Excess fat around the middle <input type="checkbox"/> Weight and/or waist size <input type="checkbox"/> Enlarged breast tissue <input type="checkbox"/> Loose, sagging skin <input type="checkbox"/> Freckles, sun spots <input type="checkbox"/> Back acne <input type="checkbox"/> Other	<input type="checkbox"/> Energy, stamina <input type="checkbox"/> Focus, brain foginess <input type="checkbox"/> Memory <input type="checkbox"/> Muscle mass/strength <input type="checkbox"/> Sleep quality <input type="checkbox"/> Low libido <input type="checkbox"/> Sexual arousal or satisfaction <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Erectile dysfunction <input type="checkbox"/> Workout recovery <input type="checkbox"/> Other



Male Interest Questionnaire

Please list in order of importance your top 3 areas of concern:

- 1. _____
- 2. _____
- 3. _____

I am interested in the following services:

Please check all that apply.

<u>SKIN</u>	<u>BODY</u>	<u>MEDICAL</u>
<input type="checkbox"/> HydraFacial MD	<input type="checkbox"/> Vanquish Body Contouring	<input type="checkbox"/> HCG Weight Loss
<input type="checkbox"/> Chemical Peels	<input type="checkbox"/> Protégé Skin Tightening	<input type="checkbox"/> B-12 Injections
<input type="checkbox"/> Microneedling/Dermapen	<input type="checkbox"/> Exilis Body Sculpting	<input type="checkbox"/> Testosterone Optimization
<input type="checkbox"/> Acne Treatments	<input type="checkbox"/> Laser Hair Reduction	<input type="checkbox"/> Liposuction
<input type="checkbox"/> BOTOX Cosmetic	<input type="checkbox"/> Laser Vein Treatments	
<input type="checkbox"/> Dermal Fillers (i.e. Juvederm, Restylane)	<input type="checkbox"/> HydraFacial Back Treatments	
<input type="checkbox"/> Laser Hair Reduction		
<input type="checkbox"/> BBL/PhotoFacial		
<input type="checkbox"/> MicroLaserPeel		
<input type="checkbox"/> Profractional Laser Peel		
<input type="checkbox"/> Protégé Skin Tightening		
<input type="checkbox"/> Skin Care Products		

Please list in order of importance your top 3 services you are interested in learning more about:

- 1. _____
- 2. _____
- 3. _____

Notes:
