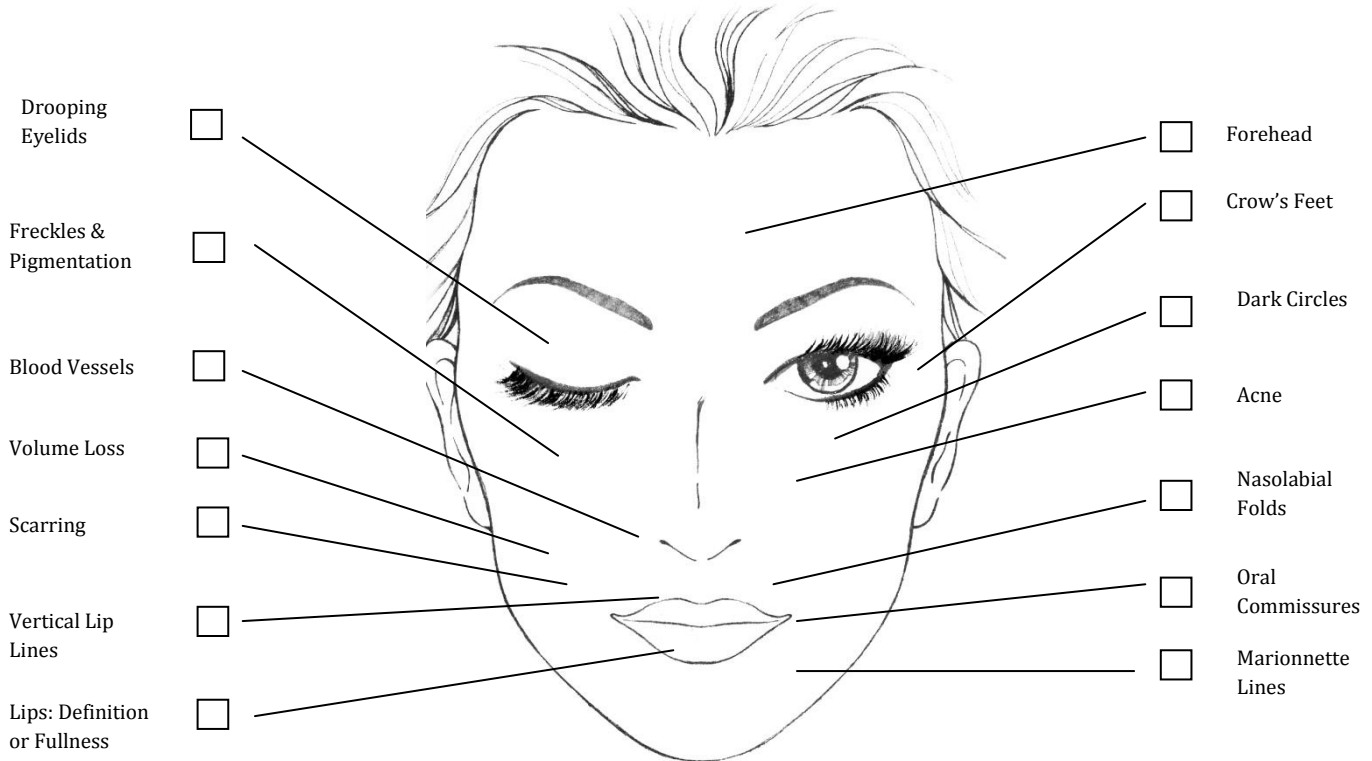


Cosmetic Consult

Name: _____ Date: _____

Please check the concerns you currently feel or would like to discuss with Dr. Kleydman or the cosmetic coordinator.



- | | | |
|---|---|--|
| <input type="checkbox"/> Acne Scars | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Hand rejuvenation |
| <input type="checkbox"/> Enlarged pores | <input type="checkbox"/> Dermal fillers | <input type="checkbox"/> Under eye wrinkles |
| <input type="checkbox"/> Surgical Scars | <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Leg Vein Removal |
| <input type="checkbox"/> Stretch Marks | <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Microneedling |
| <input type="checkbox"/> Brown Spots | <input type="checkbox"/> Hair Restoration | <input type="checkbox"/> Volume loss |
| <input type="checkbox"/> Rosacea | <input type="checkbox"/> Loose skin | <input type="checkbox"/> Non surgical nose job |
| <input type="checkbox"/> Melasma | <input type="checkbox"/> Wrinkle removal | |
| <input type="checkbox"/> Under chin fat | <input type="checkbox"/> Vampire facial | |
| <input type="checkbox"/> Skin Care | <input type="checkbox"/> Facial Veins | |

OTHER _____

What would your budget amount be to treat your concern(s)?

- <\$500 \$1000-\$2000 >\$3500

