

Name: _____

Date of birth: _____

Height _____ Weight _____

Please tell us your main concerns that brought you to our office today: _____

I have the following concerns/interests, (please check any conditions that you would like to discuss with Dr. Bartlett):

Aging appearance of my:

- Skin
- Face
- Eyes
- Lips and mouth
- Neck
- Furrowed brow
- Puffy eyelids
- Thin Lips
- Heavy Jowls
- Double chin
- Facial folds and creases
- Fine lines and wrinkles
- Sun damage (see "skin")
- Teeth
- Loss of facial fullness

Breast:

- Size
- Shape
- Position, sagging
- Symmetry between my breasts

Facial appearance/proportion of my:

- Eyes
- Nose
- Ears
- Cheeks
- Lips
- Jaw
- Chin

Body:

- Arms
- Back
- Breast
- Upper Abdomen
- Lower Abdomen
- Buttocks
- Hips
- Inner Thighs
- Outer Thighs
- Legs
- Excess Fat Deposits
- Exaggerated curves
- Lack of defined curves

Skin:

- Face or leg Veins
- Irregular scars
- Moles, lesions or other growths
- Unwanted hair
- Hair Loss
- Brown spots/Sun spots
- Redness of skin/Rosacea
- Texture of skin
- Dry skin
- Laxity of skin
- Oily skin
- Acne

Functional issues:

- Difficulty breathing
- Scar tissue
- Pain

Please check any health problems, past or present:

- | | | | | |
|--|---|---|---|--------------------------------------|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Cancer (Type: _____) | <input type="checkbox"/> Stomach problems | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Hormonal Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cystic Acne | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Cold sores/Herpes | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> HIV/ARC/AIDS | <input type="checkbox"/> Lupus, scleroderma | <input type="checkbox"/> Psychiatric problems | |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Keloid scars | <input type="checkbox"/> Weight loss |

Other: _____

Please list any previous surgical procedures: _____

Family history of medical conditions, cancer? Please list: _____

