

Personal Beauty Checklist®

Name: _____ Date: _____ Date of Birth: _____

Please place a check next to any area of concern.

Forehead lines
 Frown lines

Hair loss

Droopy brows
 Eyelid skin
 Crow's feet
 Dark Circles
 Crepey skin
 Eyelashes
 Puffy lower eyes
 Hollow lower eyes

Nose shape
 Nose size
 Difficulty breathing

Protruding ears
 Large earlobes

Acne
 Acne scarring
 Brown spots
 Large pores
 Broken capillaries
 Fine lines
 Hollow cheeks

Laugh lines (nasolabial folds)

Lip lines
 Lip size/shape
 Corners of mouth

Heavy jowls

Chin size
 Chin dimpling

Neck skin
 Neck bands
 Double chin

Sun damaged chest (decollete)

CoolSculpting: Non Invasive Fat Reduction

- Abdomen Flanks (love handles) Inner/Outer Thighs Bra Bulge

Other: _____