Paul T. Stallman, MD

Oculoplastic and Aesthetic Facial Surgery

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* Patient's Name: _____ Today's Date: _____

Email: _____

May this email be used to notify you of news, updates or specials? □ Yes □ No

How did you hear about us?_____

* Are you concerned with any of the following? (check all that apply)

□ Droopy / puffy lids	□ Dark circles under eyes	□ Loose Neck
□ Jowls	□ Heavy Brows	□ Skin Wrinkles
□ Skin spots / Texture	□ Folds along nose – Nasolabial folds	□ Frown Lines
□ Crows Feet	□ Lines around lips	□ Length of lashes

□ Other: please specify: _____

* Are you interested in any of the following? (check all that apply)

□ Eyelid Surgery	□ Brow Lift	□ Face Lift
□ Neck Lift	□ Chemical Peels	□ Botox ®
□ Laser Skin Treatment	□ Dermal Fillers	□ Dysport ®
□ Skin Care Products	□ Sun Protection	□ Latisse-Longer Lashes

* Please list any cosmetic procedure(s) you have previously had: (facial, chemical peel, Botox, lasers, plastic surgery, etc)_____

_____

* Please list skin care products you are currently using on your face._____

_____

* Any history of Keloid Scars, Acutane use, Oral Herpes?_____

_____

Thank You!