TERSA
ORAL AND FACIAL SURGERY

**Patient's Name: _____ DOB: _____**

**<u>Patient Concerns</u>:**

**Please check all that apply**

**_____ Brown/Age Spots**
**_____ Rosacea/Redness**
**____ Wrinkles**
**____ Skin Tone/Texture**
**____Sun Damage**
**____ Melasma**
**____ Pore Size**
**____ Acne**
**____ Loose Skin**
**____ Blood Vessels/Facial Veins**
**____ Skincare**

**_____Eyelid surgery (Blepharoplasty)**
**____ Protruding ear (Otoplasty)**
**____ Eyebrow/Forehead Lift**
**____ Face Lift**
**____ Redundant skin in the neck**
**____ Botox**
**____ Fillers**
**____ Acne scars**
**____ Fine lines**
**____ Stubborn fat**
**____ Other (please describe)**

**Tersa Oral and Facial Surgery**
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