

Patients Name: _____

MD/RN: _____ Surgery Date: _____

FORE HEAD

# Passes	Joules

UPPER EYELIDS

# Passes	Joules

CROW'S FEET

# Passes	Joules

LOWER EYELIDS

# Passes	Joules

CHEEKS

# Passes	Joules

NOSE

# Passes	Joules

PERIORAL

# Passes	Joules

UPPER LIP

# Passes	Joules

