Customizable aesthetic interest questionnaire

Template for clients

Patient first and last name: _____

Date of birth: _____ Phone number: _____

Email: _____ Insurance company provider: _____

☐ Check the box if you agree to receive promotional emails (newsletters, discounts, membership, and loyalty programs).

What specific areas of your face or body are you most concerned about?

Face

- ☐ Fine lines & wrinkles
- ☐ Sagging facial or neck skin
- ☐ Submental fullness (double chin)
- ☐ Facial volume loss (cheeks, under eyes)
- ☐ Droopy brows/eyelids
- ☐ Thin lips
- ☐ Aging mouth/smokers' lines
- ☐ Sparse eyelashes or brows
- ☐ Acne
- ☐ Enlarged pores
- ☐ Age spots/brown spots
- ☐ Facial blemishes/skin tags/milia (bumps)
- ☐ Blotchy/uneven skin
- ☐ Unwanted facial hair

Other _____

_____

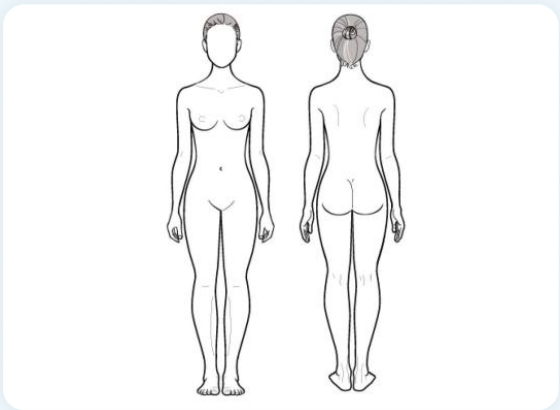
Body

- ☐ Excess body fat
- ☐ Lack of muscle tone/definition
- ☐ Sagging body skin
- ☐ Spider veins on legs
- ☐ Nail fungus
- ☐ Moles and/or skin growths
- ☐ Surgical/facial scars
- ☐ Unwanted body hair
- ☐ Excessive underarm sweating
- ☐ Unwanted tattoo(s)
- ☐ Urine leakage with sneeze or cough
- ☐ Sudden urgency to urinate

Other _____

_____

Please circle the area(s) of your interest:



How would you rate the quality of your skin?

☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

Are there any particular issues (like wrinkles, sagging, or pigmentation) you'd like to discuss?

☐ No ☐ Yes _____

What brought you to the clinic today and what would you like to improve?

_____

_____

What are your expectations for the treatment results?

_____

_____

Have you undergone any cosmetic procedures in the past, such as injections, laser treatments, or surgery?

☐ No ☐ Yes

If so, please describe the procedures and when they were performed _____

_____

Did you experience any side effects or complications? _____

_____

What is your general state of health? Do you have any chronic health conditions?

_____

Do you smoke or consume alcohol? If so, how often?

_____

Are you taking any medications or supplements?

_____

Do you have any allergies or sensitivities?

_____

Are you open to invasive procedures, such as surgery or injections?

_____

Are there any treatments you would like to avoid?

_____