## Patient Interest Questionnaire

Date: Age: Name: Please indicate any areas of concern for you Check all that apply. **Forehead** Lip lines appearance and texture Frown lines Thin lips Double chin Crow's feet lines Thinning or **Flattened** cheeks/ inadequate sunken cheeks lashes Lines and Skin wrinkles appearance around and texture the nose and mouth

Please complete questionnaire on back side.



## Patient Interest Questionnaire

## Share how you see yourself

I feel like   look: Check all that apply.	Sad Angry Tired	Less lively Fearful Saggy	Pained Less desirable Older than I feel	Other
FOR USE WITH YOUR AESTHETIC PROVIDER				
			nd aesthetic goal ch consultation	als to
Patient name:			Next appoint	ment date: / /