Allergan MEDICAL INSTITUTE
Advancing Excellence in **Facial Aesthetics**

Patient Interest Questionnaire

Name: Age: Date: / /

Please indicate any areas of concern for you

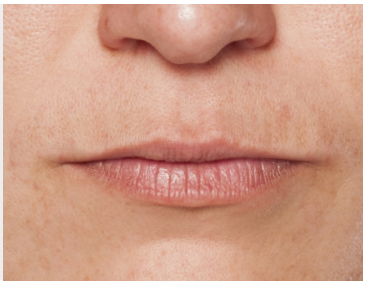
Check all that apply.

- ☐ Forehead lines

- ☐ Lip appearance and texture

- ☐ Frown lines

- ☐ Thin lips



- ☐ Crow's feet lines

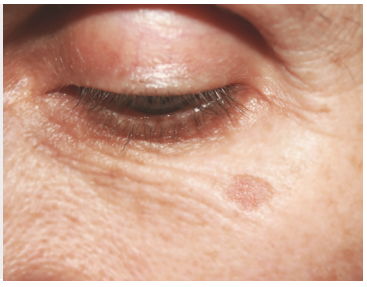
- ☐ Double chin

- ☐ Flattened cheeks/ sunken cheeks

- ☐ Thinning or inadequate lashes

- ☐ Lines and wrinkles around the nose and mouth

- ☐ Skin appearance and texture



Please complete questionnaire on back side.

Aesthetic specialist: See the next page to create the patient's treatment recommendations.

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Patient Interest Questionnaire

Share how you see yourself

I feel like I 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

Evaluate concerns and aesthetic goals to customize each consultation

Patient name: Next appointment date: / /