

# PATIENT INTEREST QUESTIONNAIRE

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**I. Please indicate the following services, products, procedures and/or health issues of interest to you (please check all the boxes that apply).**

- |   |  |
|---|--|
| <input type="checkbox"/> Botox Treatments for facial frown lines                                | <input type="checkbox"/> Facial contouring/ Facial Implants                              |
| <input type="checkbox"/> Lip Augmentation   | <input type="checkbox"/> Skin Care Program for sun damage and wrinkles                   |
| <input type="checkbox"/> Restylane/Juvederm: volume replacement therapy for wrinkles            | <input type="checkbox"/> H Abdominoplasty /Tummy Tuck                                    |
| <input type="checkbox"/> I Liposculpture for removal of unwanted fat deposits (body contouring) | <input type="checkbox"/> Liver Spots/ Age Spots  |
| <input type="checkbox"/> Hair thinning/ Hair Replacement therapy                                | <input type="checkbox"/> Blepharoplasty for helping puffy/sagging eyes                   |
| <input type="checkbox"/> L Dermabrasion (acne, pox scars)                                       | <input type="checkbox"/> L Rhinoplasty/ Prominent Nose                                   |
| <input type="checkbox"/> Aesthetic Breast Surgery/ Breast Augmentation                          | <input type="checkbox"/> I TMJ Therapy   |
| <input type="checkbox"/> IPL Photofacials/ Pixel Therapy  | <input type="checkbox"/> L Weekned LIFT/Face and Neck lift                               |
| <input type="checkbox"/> Laser Resurfacing/ Chemical Peels for facial skin improvement          | <input type="checkbox"/> Laser Hair Removal of the face, legs, underarms and bikini area |
| <input type="checkbox"/> I Dental Implant   | <input type="checkbox"/> Laser Therapy for Spider Veins of the face and legs             |
| <input type="checkbox"/> Oral Surgery, please specify: _____                                    | <input type="checkbox"/> Corrective Jaw Surgery  |

**II. Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.**

A. When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<i>Younger than</i>		<i>True Age</i>		<i>Older Than 5</i>
	1	3	4	
	2			

B. When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my face.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

**III. How did you hear about us?**

- My physician (full name) \_\_\_\_\_
- The yellow pages (specify advertisement) \_\_\_\_\_
- A friend or family member (name) \_\_\_\_\_
- Another person not listed above (name) \_\_\_\_\_

*Please provide the name and address of the person who referred you so we can thank them.*

\_\_\_\_\_

Internet \_\_\_\_\_

A seminar where I saw the doctor. The event took place on ( date) \_\_\_\_\_

(location) \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_