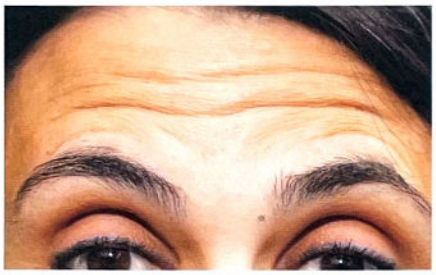
Allergan MEDICAL INSTITUTE
Advancing Excellence in Facial Aesthetics

Patient Interest Questionnaire

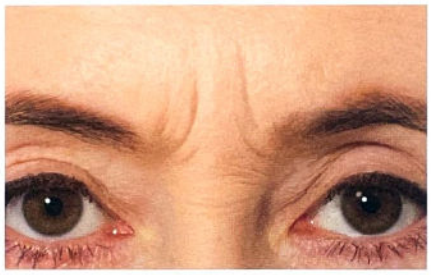
Name: Age: Date: / /

Please indicate any areas of concern for you.

Check all that apply.

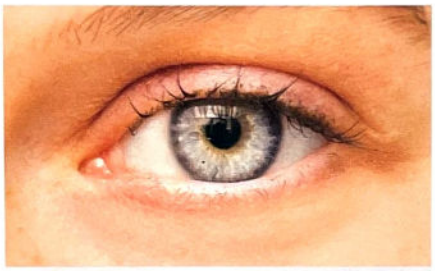


☐ Forehead lines

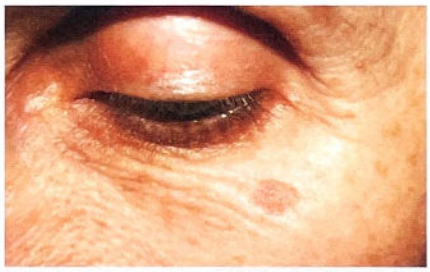


☐ Frown lines

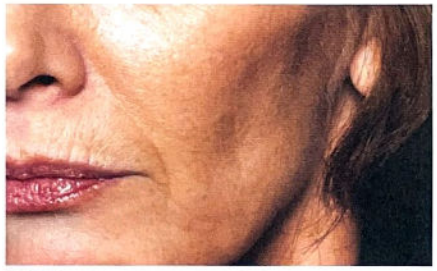
☐ Crow's feet lines



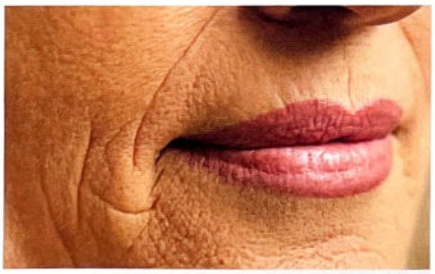
☐ Thinning or inadequate lashes



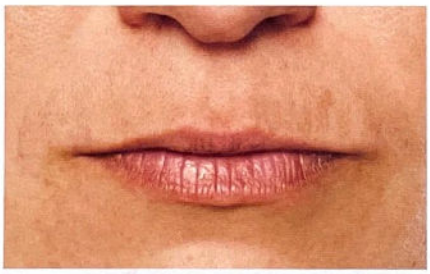
☐ Skin texture and appearance



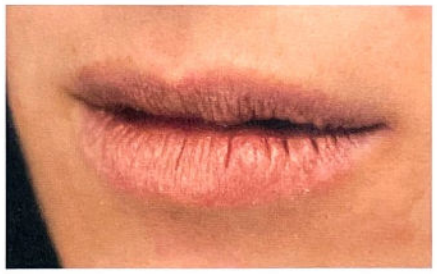
☐ Flattened cheeks/sunken cheeks



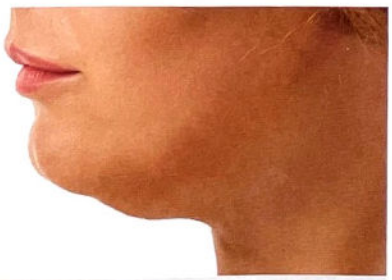
☐ Lines and wrinkles around the nose and mouth



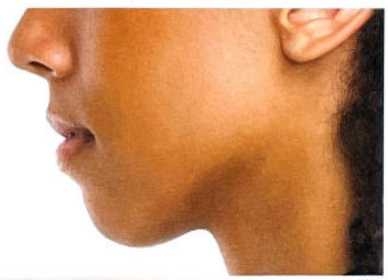
☐ Thin lips



☐ Lip appearance and texture



☐ Double chin



☐ Small chin/weak chin profile

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 I look tired
- ☐ I feel I look sad
- ☐ I feel I look angry
- ☐ I feel I have saggy skin
- ☐ I feel I look older than my age
- ☐ I feel I don't look contoured
- ☐ I feel I don't look smooth
- ☐ I feel I don't look aesthetically pleasing
- ☐ Other

FOR USE WITH YOUR AESTHETIC PROVIDER

Evaluate concerns and aesthetic goals to customize each consultation

Patient name:

Next appointment date: / /

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