

Aesthetic Interest Questionnaire

DR. BELA
CLINIC

Date: _____

Patient name: _____

Date of birth: _____

What is the main reason for your visit today?

I would like to be advised on:

How I can look better for my age

How I can change something that has been bothering me for years

How I can look more attractive

Other: _____

Have you had a consultation or treatment for a cosmetic procedure before?

Yes

No

How often do you think about wanting a cosmetic procedure?

Most days

Weekly

Monthly

Which three statements best reflect how you would like to look and feel after the treatment?

I want to look less tired

I want a less saggy appearance

I want my face to look slimmer

I want to look less angry

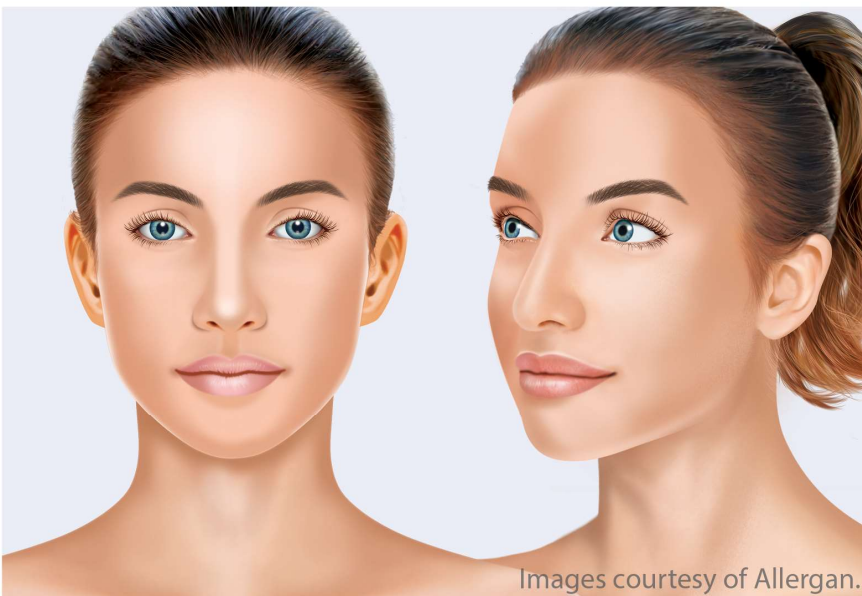
I want to look more youthful

I want softer features

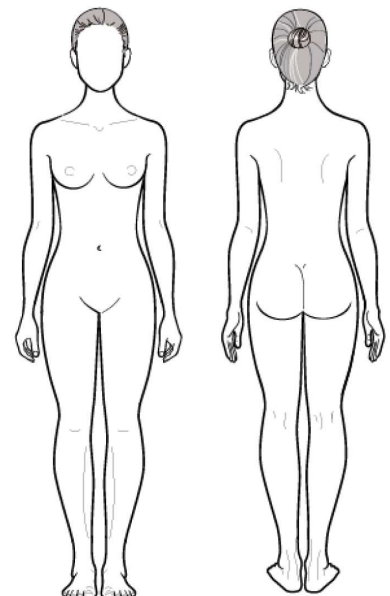
I want to look less sad

I want to look more attractive

Please circle the area(s) of your interest:



Images courtesy of Allergan.



How would you rate the quality of your skin?
(Please circle the appropriate answer)

Poor Fair Good Very Good Excellent

If you could enhance an aspect of your skin,
what would you enhance?
(Please circle the appropriate answer)

Hydration Elasticity Smoothness Color

These treatments/products interest me:
(Please circle the treatment area(s) that interest you)

SKIN	FACIAL	BODY	TREATMENTS/BRANDS
Acne	Lines and wrinkles	Belly fat	Anti-aging injections
Signs of aging	Nose to mouth lines	Loose skin	Dermal fillers
Scars	Jaw line undefined	Stubborn fat	Lip fillers
Blotchy skin	Chin – sagging skin	Arm and knee fat	Body sculpting
Dull skin	Tired look/tear trough	Inner & outer thigh fat	Facial volumizing
Moles	Sagging skin face	Back fat	<i>Retinol based skin care</i>
Sun damage	Thin lips	Love handles	
Rosacea	Loss of facial volume		

How did you hear about us?

- | | |
|---|--|
| <input type="checkbox"/> My doctor | <input type="checkbox"/> Search engine |
| <input type="checkbox"/> My insurance company
provider | <input type="checkbox"/> Social media platform |
| <input type="checkbox"/> Advertisements/periodicals | <input type="checkbox"/> Seminar |
| <input type="checkbox"/> A friend or family member | <input type="checkbox"/> Other |

Contact information

- I would like to receive information about new products/trends/our clinic
- You are allowed to contact me for further questions concerning an appointment at your clinic

Phone number: _____

E-mail address: _____

Signature: _____