Allē

# Patient Interest Questionnaire

Name: Age: Date: / /

## Please indicate any areas of concern for you.

Check all that apply.

☐ Forehead lines

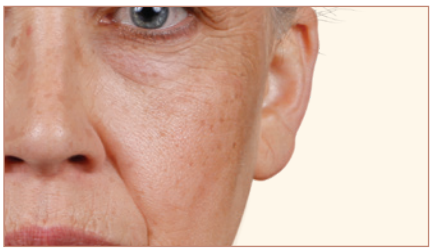
☐ Frown lines

☐ Crow's feet lines

☐ Sunken/hollow temple area

☐ Thinning or inadequate lashes

☐ Undereye area

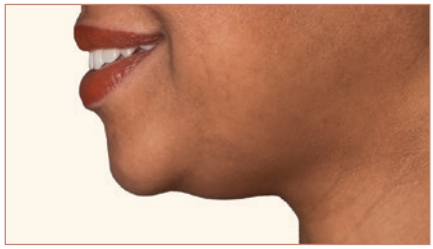


☐ Flattened cheeks/sunken cheeks

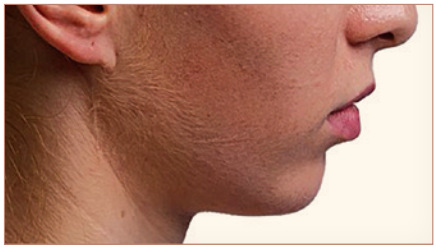
☐ Lines and wrinkles around the nose and mouth

☐ Thin lips

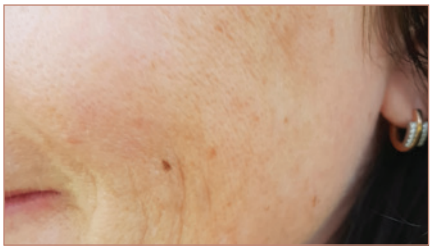
☐ Lip appearance and texture



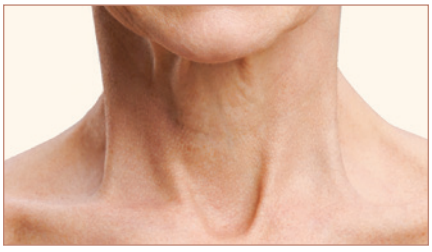
☐ Double chin



☐ Small chin/weak chin profile



☐ Skin texture and appearance



☐ Prominent neck muscles

*Models shown here are not actual patients.*

**Please complete the questionnaire on the back.**

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# Patient Interest Questionnaire

## Current Aesthetic Concerns

- ☐ I feel like I look tired
- ☐ I feel like I look sad
- ☐ I feel like I look angry
- ☐ I feel like I have sagging skin
- ☐ I feel like I look older than my age
- ☐ Other

**Which goal(s) do you identify with?**

- ☐ Beautification
- ☐ Positive aging
- ☐ Transformation
- ☐ Correction

## Please Tell Us About Your Medical and Skincare History

| | | Yes | No |
|---|---|---|---|
| 1. | Do you have any current inflammatory skin conditions (eg, acne, rosacea, dermatitis)? | ☐ | ☐ |
| 2. | Have you recently had an infection of any kind (eg, sinus, urinary tract)? | ☐ | ☐ |
| 3. | Have you recently had the flu or another viral illness? | ☐ | ☐ |
| 4. | Do you have a history of oral herpes? | ☐ | ☐ |
| 5. | Do you have any active autoimmune diseases (eg, lupus, rheumatoid arthritis)? | ☐ | ☐ |
| 6. | Do you have any allergies? | ☐ | ☐ |
| 7. | Have you had surgical or nonsurgical cosmetic procedures before? | ☐ | ☐ |
| 8. | Have you had any dental procedures or visits to the oral hygienist in the past month? | ☐ | ☐ |
| 9. | Do you have any dental procedures or visits to the oral hygienist planned in the next month? | ☐ | ☐ |
| 10. | Have you had any medical procedures or immunizations in the past month? | ☐ | ☐ |
| 11. | Do you have any medical procedures or immunizations planned in the next month? | ☐ | ☐ |
| 12. | Have you had any previous facial injectable treatments? | ☐ | ☐ |
| 13. | Are you taking any blood thinners (eg, aspirin, nonsteroidal anti-inflammatory drugs) or do you consume blood-thinning products (eg, salmon oil, vitamin E, gingko biloba, red wine, dark chocolate, grapefruit)? If so, are you prepared to avoid these in the week before your treatment? | ☐ | ☐ |
| 14. | Are you pregnant or think you might be? | ☐ | ☐ |
| 15. | Are you breastfeeding? | ☐ | ☐ |
| 16. | What is your current skincare regimen? | | |

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