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

- ☐ Lines and wrinkles around the nose and mouth

- ☐ Flattened cheeks/sunken cheeks

- ☐ Do you pee a little when coughing, sneezing, laughing, running, jumping

- ☐ On a scale of 1-5 (5 being mind blowing) how do you rate the following?

Your sex drive (desire to have sex) _____

Ability to become aroused and lubricated _____

Ability to reach orgasm _____

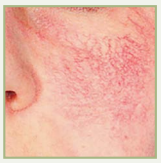
- ☐ Thin Lips

- ☐ Thinning or inadequate lashes

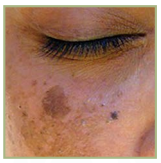
- ☐ Unwanted hair

- ☐ Unsightly scars

- ☐ Broken blood vessels



- ☐ Brown spots on face, chest, arms, hands



- ☐ Sore/tight muscles in back or neck

- ☐ Fatigue or low energy levels

- ☐ Tattoo you dislike

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