THE AESTHETICS COLLECTION EVERY FACE SINGS ITS OWN SONG PRE-CONSULTATION QUESTIONNAIRE Patient name Date ♣ GALDERMA The pre-consultation questionnaire is designed to help you and your health care professional to tailor a facial aesthetic treatment plan together according to your unique wants and needs as well as to your skin condition and facial features.

Click to paste your photo here

All information will be kept strictly confidential between you and your health care professional.

AESTHETIC PROCEDURES BACKGROUND

1. Have you ever seen any practitioners about your appear	arance?
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No	Dermatologist	Aesthetic nurse
Surgeon (plastic/cosmetic)	Cosmetic dentist	Beauty Therapist
Aesthetic Doctor		
Other (please specify):		

2. Have you previously had any aesthetic procedures or surgery, if yes please specify?

No	Permanent filler injections
Botulinum toxin injections	Facelift
Dermal filler injections (hyaluronic acid, collagen)	Rhinoplasty (nose surgery)
Collagen stimulators	Maxillofacial surgery
Skin boosting injections	Eyelid surgery
Threads	
Other (please specify)	

3. Are you on any medication or do you have any past or current medical conditions?

Yes No Please specify _____



YOUR MOTIVATIONS

4. Why is it important for you to have this procedure at this particular time in your life?

I am doing this for myself

I am preparing for a milestone event (e.g. wedding, significant birthday etc.)

I am dealing with life-changing events (e.g. divorce, bereavement, relationship problems, change in employment etc.)

I want to please my partner, friends or family

People I know or admire are having treatments and I like how they look

- 5. How often do you check your appearance each day? (Looking in the mirror or on your phone for instance)
 - < 5 times
- 5-10 times

10-20 times

>20 times

- 6. If you take selfies each day, how many do you take?
 - 0
- 1-5 times

6-15 times

>15 times

Do you use a filter to amend your appearance?

Yes

No

7. How quickly are you expecting to see the results?

Immediately (<3 weeks)

Quickly (1-2 months)

Progressively (3 months and onwards)

8. Please circle how you have felt over the past few weeks













FACIAL MAPPING

Please mark the area(s) or feature(s) that you would like to improve. This will help you and your practitioner to build your individualized treatment program.







