Bengtson Center
for AESTHETICS & PLASTIC SURGERY

Cosmetic Interest Questionnaire

Patient Name: ____ Date: ________________

Home Phone: _____________________________ Cell Phone: ______________________________

Address: ____

City:___________________________________ State:____________ Zip: ________________

Email: ____ DOB: ________________

- ☐ BOTOX® Cosmetic (Botulinum Toxin Type A)
- ☐ Fillers (Belotero Balance®, Radiesse®, Restylane®, Juvéderm®, Juvéderm Voluma® XC)
- ☐ Sun Damage
- ☐ Dermal Infusion Facial, Micro-Dermabrasion
- ☐ Age Spots
- ☐ Laser Treatments
- ☐ Laser Hair Removal
- ☐ Facial Redness
- ☐ Micro-Needling Skin Rejuvenation
- ☐ VISIA® Complexion Analysis
- ☐ Fine Line/Wrinkles
- ☐ Hyper-Pigmentation (red or brown spots)
- ☐ Broken Capillaries
- ☐ Acne or Scarring
- ☐ 3D Imaging of Face-Breast-Body
- ☐ Fat Injections
- ☐ Cellfina™ Cellulite Removal
- ☐ Breast Augmentation
- ☐ Secondary Breast Augmentation
- ☐ Breast Lift
- ☐ Breast Reduction
- ☐ Face Lift
- ☐ Ultherapy® Skin Firming & Rejuvenation (In Office/Non-Invasive)
- ☐ Double Chin Treatments (CoolMini™ & Kybella™)
- ☐ CoolSculpting® Body Contouring (In Office/Non-Invasive)
- ☐ SlimLipo™ Laser Liposuction
- ☐ Tummy Tuck
- ☐ Nose Reshaping
- ☐ Eye Lid Lift
- ☐ Latisse®, Eyelash Enhancement System
- ☐ Tattoo Removal
- ☐ Post Weight Loss Surgery
- ☐ Upper & Lower Body Lift
- ☐ Thigh Lift
- ☐ Upper Arm Lift
- ☐ Brazilian Buttocks Lift
- ☐ Body Lift
- ☐ Excessive Under Arm Sweating
- ☐ Spiders Veins/Sclerotherapy
- ☐ Other: ____

____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than | True Age | Older Than

1 • • • • • **2** • • • • • **3** • • • • • **4** • • • • • **5**

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned | Somewhat Concerned | Very Concerned

1 • • • • • **2** • • • • • **3** • • • • • **4** • • • • • **5**

How may we best contact you?

☐ cell ☐ home phone ☐ text message ☐ e-mail ☐ postal service

How did you hear about us?

☐ A friend or family member (name)? ______________________

☐ Were you a prior patient of Dr. Bengtson? ______________________

☐ Internet? Specific website? ______________________

☐ Facebook? ______________________

☐ Seminar or event? The event took place on (date) ______________________

☐ Magazine or Newspaper (which one)? ______________________

☐ Television ______________________

______________________ Thank you!

Patient Signature

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