

PRE-CONSULTATION QUESTIONNAIRE

Patient name

Date

Contact number

AESTHETIC PROCEDURES BACKGROUND

1. Have you ever seen any practitioners about your appearance?

- ☐ No ☐ Dermatologist ☐ Aesthetic Doctor
☐ Surgeon (plastic/cosmetic) ☐ Cosmetic dentist ☐ Beauty Therapist
☐ 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 specific: _____

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



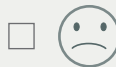
7. How quickly are you expecting to see the results?

☐ Immediately
(<3 weeks)

☐ Quickly
(1-2 months)

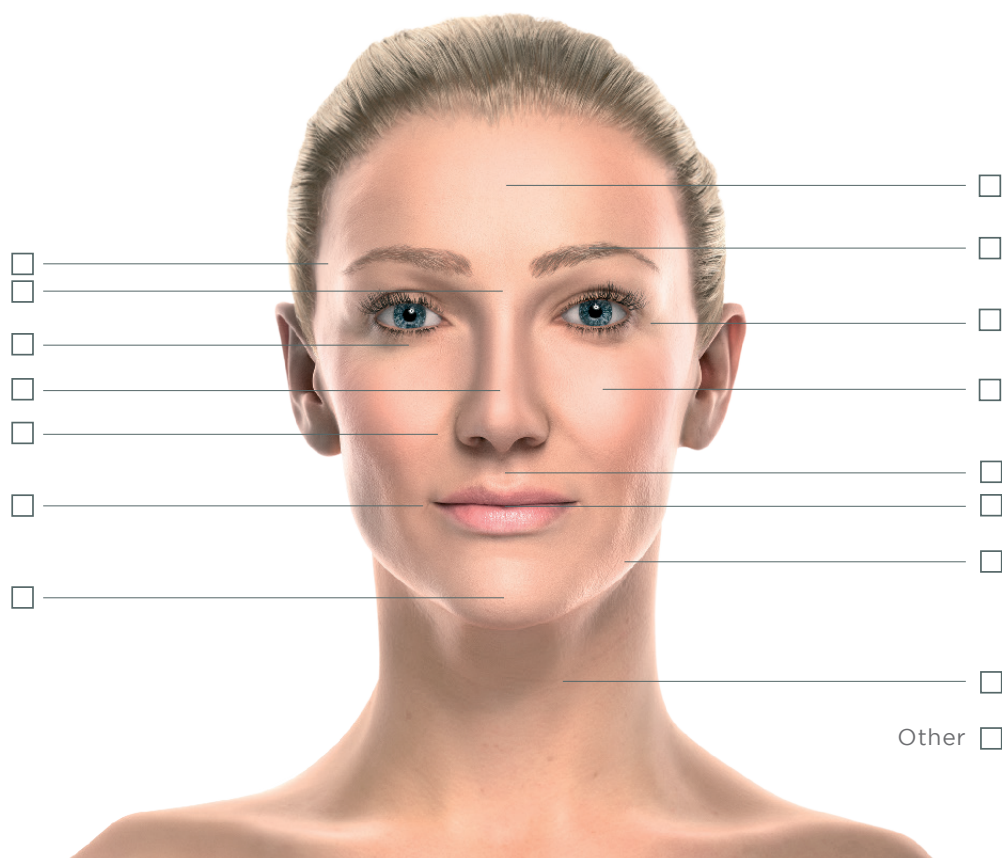
☐ Progressively
(3 months and onwards)

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.



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