

Patient Questionnaire

1. Are you worried about how you look? Yes No
2. Do you think about your appearance all the time and wish you could think about it less? Yes No
3. Please list the body areas you don't like: _____

4. How many plastic surgeons have you seen? _____
5. Have you had plastic surgery before? _____
6. Were you satisfied with your prior plastic surgery? _____
7. Is your main concern that you aren't thin enough or that you might get too fat?
Yes No
8. How has this problem with how you look affected your life? _____

Are you often upset about how you look? Yes No
9. Has it often gotten in the way of doing things with friends or dating? Yes No
If yes describe: _____

10. Has it caused you any problems with school or work? Yes No
If yes: What are they? _____

11. Are there things you avoid because of how you look? Yes No
If yes: What are they? _____

12. On an average day, how much time do you usually spend thinking about how you look?
(Add up all the time you spend in a day, and then circle one.)
A. Less than 1 hour a day.
B. 1-3 hours a day
C. More than 3 hours a day.