

## Patient's Questionnaire

Patient No. \_\_\_\_\_ Date \_\_\_\_\_

Follow-up timepoint:  1-month  3-month  6-month  10-month

### 1. Please grade your satisfaction with the treatment results:

-3 = very dissatisfied  -2 = dissatisfied  -1 = slightly dissatisfied

0 = neutral

1 = slightly satisfied  2 = satisfied  3 = very satisfied

### 2. Do you have any comments & concerns about the treatment you received?

No

If yes, please specify \_\_\_\_\_

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### 3. Have you experienced any discomfort & adverse event after the treatment?

No

If yes, please specify \_\_\_\_\_

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**Thank you for completing the questionnaire.**