Patient satisfaction Follow up sheet - Vulvar fillers

Patient Name / ID : _____
Date of Treatment : _____
Provider : _____

2 Week Follow up

Question		Response Option	Note
1	Have you experienced any discomfort, swelling pain?	None mild/moderate/Severe	
2	Any visible lumps, unevenness, or nodules?	Yes/No	
3	Are you satisfied with the symmetry appearance?	Yes/No/Somewhat	
4	Do you feel any tenderness during touch or pressure	Yes/No	
5	Do you feel more confident or comfortable post treatment?	Yes/No/Not Sure	
6	Additional comments Or concerns		

Action Taken (if needed)

- ☐ No issues
- ☐ scheduled follow up in clinic
- ☐ Advised massage
- ☐ Referred for correction
- ☐ Other

3 Month Follow up

Question		Response Option	Note
1	How would you rate your overall satisfaction with the results?	Very Satisfied/Satisfied/Neutral/Dissatisfied	
2	Have Her results met your expectations?	Yes/No/Partially	
3	Any late onset issues? (hardness, nodules, Changes)	Yes/No	
4	would you consider having this treatment again?	Yes/No/Not sure	
5	Any functional or comfort improvements (eg. Clothing, intimacy)?	Yes/No/Not Applied	
6	Additional comments Or Suggestions		

Follow up plan

- ☐ Routine monitoring
- ☐ Touch up needed
- ☐ scheduled future appointment
- ☐ other