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truSculpt® iD

HEALTH HISTORY

PERSONAL INFORMATION

DATE: ______________________________

LAST NAME: ______________________________ FIRST: ______________________________ M.I.: __________

STREET ADDRESS: ______________________________ CITY: ____________________ STATE: ________ ZIP: __________

HOME PHONE: ______________________________ WORK PHONE: ______________________________

CELL: ______________________________ EMAIL: ______________________________

DATE OF BIRTH (MONTH/DAY/YEAR): ____________________ AGE: ______________ SEX: ☐ FEMALE ☐ MALE

WHERE DID YOU HEAR ABOUT US: (Please be specific)

INTERNET: ______________________________ REFERRAL: ______________________________

ADVERTISEMENT: ____________________ IF SO WHERE: ____________________ OTHER: ______________

I AM INTERESTED IN: (Please check all that apply)

- ☐ BOTOX
- ☐ FILLERS
- ☐ ROSACEA
- ☐ ACNE TREATMENTS
- ☐ FINE LINES/WRINKLES
- ☐ SUN DAMAGE
- ☐ CELLULITE REDUCTION
- ☐ SKIN TIGHTENING
- ☐ FAT REDUCTION
- ☐ TATTOO REMOVAL
- ☐ SKIN CARE ADVICE/PRODUCTS
- ☐ MICRODERMABRASION
- ☐ FACIAL/LEG VEIN TREATMENTS
- ☐ HAIR REMOVAL
- ☐ VAGINAL REJUVENATION
- ☐ OTHER, PLEASE SPECIFY ______________________________

DO YOU USE SUNSCREEN? ☐ YES, IF YES SPF # __________ ☐ NO

WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

☐ ALWAYS BURN, NEVER TAN ☐ USUALLY BURN, TAN WITH DIFFICULTY ☐ SOMETIMES BURN, TAN ABOUT AVERAGE

☐ ALMOST NEVER BURN, TAN VERY EASILY ☐ RARELY BURN, TAN EASILY ☐ NEVER BURN, ALWAYS TAN

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MEDICAL HISTORY: (Check the appropriate box next to any condition for which you have ever been treated)

- ☐ ACNE
- ☐ ARTHRITIS
- ☐ AUTOIMMUNE DISORDER
- ☐ BLOOD DISORDERS
- ☐ CANCER (OR RADIATION THERAPY)
- ☐ DIABETES / DIABETIC NEUROPATHY
- ☐ HERPES (OR COLD SORES)
- ☐ HIRSUTISM
- ☐ VITILIGO
- ☐ KIDNEY DISEASE
- ☐ MELANOMA
- ☐ PORT WINE STAIN
- ☐ PSORIASIS
- ☐ PACEMAKER
- ☐ SHINGLES
- ☐ SKIN PIGMENTATION
- ☐ STEROID OR HORMONAL THERAPY
- ☐ HORMONAL IMBALANCES
- ☐ POLYCYSTIC OVARIAN SYNDROME
- ☐ KELOID SCARS / OTHER SCARS

ADDITIONAL QUESTIONS:

1 ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? IF YES, PLEASE SPECIFY.

____

2 ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL PREPARATIONS, MEDICAL PATCHES OR ASA? IF YES, PLEASE SPECIFY.

____

3 DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE SPECIFY.

____

4 HAVE YOU EVER USED (OR ARE CURRENTLY USING) RETIN A OR GLYCOLIC ACID? IF YES, PLEASE SPECIFY.

____

5 HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE? IF YES, PLEASE SPECIFY.

____

6 HAVE YOU EVER HAD A CHEMICAL PEEL? IF YES, PLEASE SPECIFY.

____

7 HAVE YOU HAD ANY LASER TREATMENTS? IF YES, PLEASE SPECIFY.

____

8 WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

____

9 DO YOU HAVE ANY DENTAL OR ACRYLIC IMPLANTS, CROWNS OR BRIDGEWORK? IF YES, PLEASE SPECIFY.

____

10 DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? IF YES, PLEASE SPECIFY.

____

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11 DO YOU HAVE A PACEMAKER?

12 HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE)?
IF YES, PLEASE SPECIFY.

13 DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? IF SO, THEN HOW OFTEN?

14 HAVE YOU EVER HAD GOLD THERAPY (USED FOR RHEUMATOID ARTHRITIS)?

15 ARE YOU CURRENTLY PREGNANT?

16 HAVE YOU HAD FILLER OR BOTOX/DYSPORT INJECTIONS IN THE AREA TO BE TREATED?
IF YES, PLEASE SPECIFY.

17 DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES?

PLEASE SIGN BELOW TO INDICATE ALL THE INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE: ______________________ DATE: ______________

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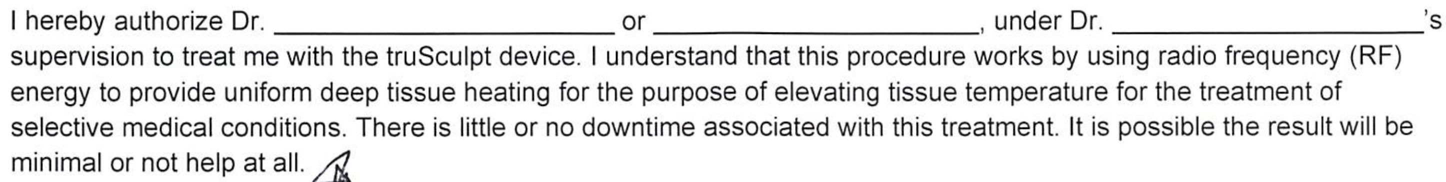
PATIENT INFORMED CONSENT FORM

***(NOTE: THIS PATIENT INFORMED CONSENT TEMPLATE IS PROVIDED "AS IS" AND IS INTENDED FOR INFORMATIONAL PURPOSES ONLY. THIS TEMPLATE MAY NOT MEET ALL STATE AND FEDERAL LEGAL OR REGULATORY REQUIREMENTS FOR USE WITH PATIENTS. PHYSICIANS USING THIS TEMPLATE ARE RESPONSIBLE FOR ENSURING THE INFORMED CONSENT FORM USED WITH PATIENTS MEETS ALL APPLICABLE STATE AND FEDERAL LEGAL AND REGULATORY REQUIREMENTS, AND ARE ENCOURAGED TO CONSULT WITH THEIR ATTORNEY.).**



I hereby authorize Dr. ________________________ or ________________________, under Dr. ______________________'s supervision to treat me with the truSculpt device. I understand that this procedure works by using radio frequency (RF) energy to provide uniform deep tissue heating for the purpose of elevating tissue temperature for the treatment of selective medical conditions. There is little or no downtime associated with this treatment. It is possible the result will be minimal or not help at all.

The procedure may result in the following adverse experiences or risks:

- **DISCOMFORT/PAIN –** Moderate discomfort during treatment is expected. Mild discomfort or slight tenderness in the treatment area may persist for a few hours following treatment, potentially extending to a few days.
- **REDNESS/SWELLING/BRUISING –** Short term redness (hyperemia) is expected following treatment and typically persists for several hours. In addition, swelling (edema) and/or bruising of the treated area may occur and typically resolve within 24 hours to a few days.
- **BRUISING/PETECHIAE OUTSIDE THE TREATMENT AREA** - May occur under the area where the decal is applied and can occur in the process of removing the decal from patient's skin.
- **LUMPS** - Firm edemic areas may develop in the treated area 24 to 72 hours following treatment, and typically resolve without intervention over several weeks. If lumps do develop, they are typically tender to touch.
- **WOUNDS –** Treatment can result in burning, blistering, crusting, scabbing or bleeding of the treated areas. If any of these occur, please call our office _____(Phone number)_____.
    - **INFECTION –** Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office_____ (Phone number)_____. It is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
    - **SCARRING –** Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
    - **SKIN COLOR CHANGES –** If the skin surface is disrupted, there is a possibility that the area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- **NUMBNESS –** Temporary numbness may occur, but is rare.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as surgery
- Reasonably anticipated health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period

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For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr. ______________________ and staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby ☐ do ☐ do not authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR THE TRUSCULPT PROCEDURE, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

______________________	______________________	______________________
Signature-Patient	**Print Name**	**Date**
______________________	______________________	______________________
Signature-Witness	**Print Name**	**Date**

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