LIFE STUDIOS

Ultherapy®

Medical History

Client Name:_____ D.O.B: _____

Address: _____

Cell: _____ Email: _____

Gender: ☐ Male ☐ Female Weight: _____ lbs. Height: _____ft. _____in.

Emergency Contact: _____ Phone: _____

Medical and Surgical History

Please answer all of the following questions

Open wounds or lesions in the area Treatment area?* ..... ☐ YES ☐ NO

Severe or Cystic Acne in the treatment Area?* ..... ☐ YES ☐ NO

Active implants (e.g., pacemakers or Defibrillators), or metallic implants in The treatment area?* ..... ☐ YES ☐ NO

Hemorrhagic or bleeding disorders?*** ..... ☐ YES ☐ NO

Pregnant or lactating?*** ..... ☐ YES ☐ NO

Migraines?*** ..... ☐ YES ☐ NO

Bell's Palsy?*** ..... ☐ YES ☐ NO

Active or local skin disease that may Alter wound healing?*** ..... ☐ YES ☐ NO

Autoimmune Disease?*** ..... ☐ YES ☐ NO

Epilepsy?*** ..... ☐ YES ☐ NO

Herpes or Cold Sores?*** ..... ☐ YES ☐ NO

Diabetes?*** ..... ☐ YES ☐ NO

Please list any Chronic Illnesses: _____

_____

Have you undergone any of the following cosmetic procedures in the treatment area:

Skin Tightening Procedure/Treatment ..... ☐ YES ☐ NO

Treatment name:_____ Area Treated: _____ Date of last Treatment: _____

Filler (e.g. Belotero®, Radiesse®) ..... ☐ YES ☐ NO

Treatment name:_____ Area Treated: _____ Date of last Treatment: _____

Fat Transfer ..... ☐ YES ☐ NO

Treatment name:_____ Area Treated: _____ Date of last Treatment: _____

Neurotoxin (e.g. Xeomin®) within the last 2-4 weeks ..... ☐ YES ☐ NO

Treatment name:_____ Area Treated: _____ Date of last Treatment: _____

Resurfacing treatment ..... ☐ YES ☐ NO

Treatment name:_____ Area Treated: _____ Date of last Treatment: _____

Facelift or blepharoplasty or brow lift ..... ☐ YES ☐ NO

Treatment name:_____ Area Treated: _____ Date of last Treatment: _____

Surgical reconstruction or Implants ..... ☐ YES ☐ NO

Treatment name:_____ Area Treated: _____ Date of last Treatment: _____

Are you currently taking the following prescription medications:

Anticoagulants or antiplatelet drugs treatment ..... ☐ YES ☐ NO

Immunosuppressant drugs treatment ..... ☐ YES ☐ NO

Accutane within the last 12 months treatment ..... ☐ YES ☐ NO

Are you allergic to any medications ..... ☐ YES ☐ NO

List any allergies: _____

List all medications or supplements below. Be sure to include all prescription or non-prescription medications.

If you are not taking any medications or supplements please check here: ☐

Medication	Diagnosis	Dose	Frequency	Start Date	Date Last Taken

*Ultherapy® is contraindicated for use

** Ultherapy® is not recommended for use directly over this

*** Ultherapy® has not been evaluated for use in this scenario

Self-Exam

The clinical response factors listed below are intended to help clinicians assess you and your potential response to Ultherapy. Please complete each section. Your clinician will assess the responses to deliver an appropriate Ultherapy treatment.

Clinical Response Factors: Circle the appropriate answer below

Age:	<35 y/o	35-49 y/o	50-64 y/o	65+ y/o
Smoking History:	Never Smoked	Ex-Smoker	Light Smoker	Heavy Smoker
Health:	No Health Issues	Minor Health Issues		Chronic Health Issues
Sun Exposure:	Never Use Sun Screen	Occasionally Use Sun Screen		Always Use Sun Screen

Clinical Response Factors: Upper Face: Check Appropriate Boxes	**None**	**Mild**	**Moderate**	**Severe**
Skin Laxity: Excess skin or hooding on the eyelid; eyelid droopiness.				
Skin Quality: Fine lines, crepiness/wrinkling, and or poor elasticity.				
Lower Face and Neck: Check Appropriate Boxes	**None**	**Mild**	**Moderate**	**Severe**
Skin Laxity: Cheek tissue decent (hollowing mid cheek, jowling, submental / under the chin laxity), downturned commissures /corners of the mouth, nasolabial folds / smile lines, & / or draping of upper neck.				
Volume of Tissue: High BMI (None 18-24.9, Mild to Moderate 25-30, Severe >30).				
Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity.				
Chest: Check Appropriate Boxes	**None**	**Mild**	**Moderate**	**Severe**
Skin Laxity: Laxity of chest tissues across upper-chest.				
Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity, sun damage.				

What are your treatment goals? _____

_____

_____

Additional Findings: _____

_____

_____

_____

Patient Signature: _____ Date: _____

Ultherapist Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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THIS SECTION IS FOR HEALTHCARE PROFESSIONAL USE ONLY

Treatment Checklist

Pre-treatment photos taken ..... ☐ YES ☐ NO

Procedure reviewed with patient..... ☐ YES ☐ NO

Patient reviewed questions answered..... ☐ YES ☐ NO

Informed consent signed..... ☐ YES ☐ NO

Photo consent signed ..... ☐ YES ☐ NO

Ultherapy treatment date: _____

Pre-Medication Order: _____

Ultherapy Treatment Record from system printed or Patient Record completed ..... ☐ YES ☐ NO

"What to Expect" pamphlet instruction given to patient..... ☐ YES ☐ NO

Follow-Up Checklist

Aesthetic care plan discussed: _____

_____

3 month follow-up appointment scheduled: _____

Face/Neck:

1st follow-up visit date: _____ Photos taken: ☐ FV ☐ R45 ☐ R90 ☐ L45 ☐ L90

2nd follow-up visit date: _____ Photos taken: ☐ FV ☐ R45 ☐ R90 ☐ L45 ☐ L90

Décolletage

1st follow-up visit date: _____ Photos taken: ☐ FV ☐ R45 ☐ R90 ☐ L45 ☐ L90

2nd follow-up visit date: _____ Photos taken: ☐ FV ☐ R45 ☐ R90 ☐ L45 ☐ L90

Clinical and Treatment Notes:

_____

_____

_____

_____

_____

_____

_____

_____

Ultherapist Signature: _____ Date: _____

Physician Signature: _____ Date: _____

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