Tighter Lines
AESTHETICS

# UltraShape Treatment Consent

I authorize Ocean Med Spa to carry out the treatment UltraShape. I understand that UltraShape is focused, pulsed mechanical ultrasound that permanently destroys fat cells in the treated area without causing damage to tissue and adjacent structures.

I am aware that UltraShape body treatments are a minimum of 3 treatments spaced every 2-4 weeks apart. I understand that clinical results may vary depending on individual factors, including but not limited to medical history, patient compliance with pre-and post-treatment instructions.

I confirm that I do not have the following contraindications to this procedure:

* Pacemaker, implanted cardiac defibrillator, or other electromagnetic implanted devices
* Pregnant, or breast feeding or anticipated pregnancy during the treatment phase
* Metabolic disorders or are currently taking any medication that could affect fat metabolism
* Hepatitis or other liver diseases
* Immune system disease or connective tissue disorders
* History of poor wound healing, an open wound or rash in the treatment area
* Keloids, hypertrophic scars, or depressed scars in the treatment area
* Blood or bleeding disorder

I give my consent to clinical photography, and I authorize the anonymous use of these photographs (unless I state and document otherwise) for the purpose of study, publication or promotional activities

I understand that there are no serious Adverse Events related to the UltraShape treatment. I can expect some mild transient redness, and blisters may occur (in rare cases 0.05% reported).

Anesthesia is not necessary. This treatment is comfortable.

I am fully aware that my concerns/conditions are of a cosmetic nature and the decision to proceed with the UltraShape procedure is entirely mine. I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications. I certify that I have read and fully understood the contents of this consent. I have been given the opportunity to ask questions.

I will notify a clinic staff member/treatment provider/Physician if my health status changes or medication is prescribed by another Physician at any time during my treatments.

Print Name: _____

Signature: _____ Date: _____

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**MEDICAL HISTORY FORM**

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: Female _____ Male _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

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Which body area/areas or condition would you like treated? _____

_____

_____

| **Please answer all of the following questions** | **YES** | **NO** |
|---|---|---|
| 1. Do you have **ANY** current or chronic medical illnesses? Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or <u>any</u> other condition or illness. Please List: _____ | O | O |
| 2. Do you have **ANY** current or chronic skin conditions? Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or <u>any</u> other skin condition. Please List: _____ | O | O |
| 3. Are you currently under a doctor's care? If so, for what reason? _____ | O | O |
| 4. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? Please List: _____ | O | O |
| 5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Please List: _____ | O | O |
| 6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)? | O | O |
| 7. Do you have **ANY** allergies to medications, foods, latex or other substances? Please List: _____ | O | O |
| 8. (For women) are you or could you be pregnant? | O | O |
| 9. (For women) are menstrual periods irregular, or have you ever been diagnosed with Polycystic Ovarian Disorder? | O | O |
| 10. Do you have a history of herpes I or II in the area to be treated? | O | O |
| 11. Do you have a history of keloid scarring or hypertrophic scar formation? | O | O |
| 12. Do you have a history of light induced seizures? | O | O |
| 13. Do you have any open sores or lesions? | O | O |
| 14. Do you have any history of radiation therapy in the area to be treated? | O | O |

**MEDICAL HISTORY, CONTINUED** **YES** **NO**

15. In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? O O
Please List product name and date last used: _____
_____

16. In the last three (3) months, have you used any of the following products: glycolic acid or other alphahydroxy or betahydroxy acid products; exfoliating or resurfacing products or treatments? O O
Please List product name and date last used: _____
_____

17. Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers,including, but not limited to, collagen, autologous fat, Restylane®, etc.? O O
If yes, please list locations on or in the body and dates: _____
_____

18. Do you have or have you ever had any Botulinums, such as Botox® or Dysport®? O O
If yes, please list locations on or in the body and dates: _____
_____

19. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? O O
20. Have you taken Tretinoin (like Retin-A, Renova) in the last 6 months? O O
21. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? O O
22. Do you have a pacemaker? O O

Please include your email address to receive appointment confirmations, and monthly information on special pricing and/or special events:

_____@_____

How did you hear about us? _____

Signature: _____ Date: _____