Tighter Lines
AESTHETICS

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: _____

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: _____

Tighter Lines
AESTHETICS

Patient name _____

Treatment sites: _____

I duly authorize _____to perform Vela*Shape* treatment.

I understand that the Vela*Shape* is a device used for improving the appearance of cellulite and reducing circumferences and that it may also be therapeutic for improving circulation and muscle aches in the treated areas. I understand there is a possibility of short-term effects such as discomfort, reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me _____ (patient's initials).

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment.

I understand that treatment with the Vela*Shape* involves a series of treatments and the fee structure has been fully explained to me _____ (patient's initials).

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature_____

Date_____

Witness_____