



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

**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?  YES  NO  
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?  YES  NO  
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.?  
If yes, please list locations on or in the body and dates: \_\_\_\_\_  YES  NO
18. Do you have or have you ever had any Botulinums, such as Botox® or Dysport®?  
If yes, please list locations on or in the body and dates: \_\_\_\_\_  YES  NO
19. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?  YES  NO
20. Have you taken Tretinoin (like Retin-A, Renova) in the last 6 months?  YES  NO
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?  YES  NO
22. Do you have a pacemaker?  YES  NO

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: \_\_\_\_\_



The SculpSure® delivers laser energy to heat the deep layer of fat. The heat that is created damages the fat cells. The damaged fat cells are then eliminated by the body through your lymphatic system.

During the laser delivery the applicators cool the skin throughout the entire treatment. The cooling protects your skin while the energy heats your fat layer. When the treatment begins, it will feel warm, and over time the heat sensation will increase to short periods of intense deep heat. You may also experience some cramping, tingling, prickling or squeezing sensations deep in the fat layer. These sensations are normal and expected. These sensations indicate that the laser is effectively targeting and damaging the fat layer.

- The SculpSure is eye safe. There is no need to wear protective eyewear.
- Your skin may be slightly pink to red immediately after treatment. This may last for a few hours.
- Following the SculpSure treatment you may experience swelling and tenderness that typically lasts for approximately 2 weeks, but may last longer. You may also experience tissue firmness or nodules. Nodules can last for days to several months, depending on the size of the nodule. This side effect will resolve on its own.
- The treated areas should be massaged two (2) times a day for five to ten (5-10) minutes. There are no lifestyle restrictions following your SculpSure treatment. It is recommended to increase your water intake after treatment.
- You may use ice packs or Tylenol according to package instructions to help ease tenderness.
- I have been thoroughly and completely advised regarding the end point of the procedure. I understand that the practice of medicine is not an exact science and no results have been guaranteed. I acknowledge that the results may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized.
- There is no guarantee that the expected or anticipated results will be achieved.

I confirm that I have not had sun exposure within the last 7 days.  Yes  No

I consent to photographs and digital images being taken and used to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed publicly for such stated purposes without my permission.  Yes  No

Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.  Yes  No

**I have read and understand all information presented to me before consenting to treatment.  
I have had all my questions answered.**

Signature

Date