OCEAN MED SPA

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: _____

OCEAN MED SPA

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