

# Ultherapy® Consult Record

Patient Name: \_\_\_\_\_ Current Date: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 E mail address: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
 Gender:  M  F Weight: \_\_\_\_\_ lbs. Height: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Cell: \_\_\_\_\_ Relation: \_\_\_\_\_

## Medical and Surgical History

Open wounds or lesions in treatment area* <input type="checkbox"/> YES <input type="checkbox"/> NO	Migraines*** <input type="checkbox"/> YES <input type="checkbox"/> NO
Severe or Cystic Acne in the treatment area* <input type="checkbox"/> YES <input type="checkbox"/> NO	Bell's palsy*** <input type="checkbox"/> YES <input type="checkbox"/> NO
Active implants (e.g., pacemakers or defibrillators), or metallic implants in the treatment area* <input type="checkbox"/> YES <input type="checkbox"/> NO	Active or local skin disease that may alter wound healing*** <input type="checkbox"/> YES <input type="checkbox"/> NO
Hemorrhagic or bleeding disorders*** <input type="checkbox"/> YES <input type="checkbox"/> NO	Autoimmune Disease*** <input type="checkbox"/> YES <input type="checkbox"/> NO
Pregnant or lactating*** <input type="checkbox"/> YES <input type="checkbox"/> NO	Epilepsy*** <input type="checkbox"/> YES <input type="checkbox"/> NO
	Herpes or Cold sores*** <input type="checkbox"/> YES <input type="checkbox"/> NO
	Diabetes*** <input type="checkbox"/> YES <input type="checkbox"/> NO

List any chronic illness: \_\_\_\_\_

Have you undergone 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  
 Product name: \_\_\_\_\_ Area treated: \_\_\_\_\_ Date of last treatment \_\_\_\_\_

**Fat transfer** .....  YES  NO  
 Source/Processing of fat: \_\_\_\_\_ Area treated: \_\_\_\_\_ Date of last treatment \_\_\_\_\_

**Neurotoxin (e.g. Xeomin® )** within the last 2-4 weeks.....  YES  NO  
 Product 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.....  YES  NO  
 Immunosuppressant drugs.....  YES  NO  
 Accutane within the last 12 months.....  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	Disease/Reason	Dose	Frequency	Date started	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

# Ultherapy® Consult Record

## 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:	None	Mild	Moderate	Severe
<b>Upper face: Check the appropriate boxes</b>				
<b>Skin Laxity:</b> Excess skin or hooding on the eyelid; eyelid droopiness				
<b>Skin Quality:</b> Fine lines, crepiness/wrinkling, and/or poor elasticity				
<b>Lower face and neck: Check the appropriate boxes</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
<b>Skin Laxity:</b> 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				
<b>Volume of Tissue:</b> High BMI (None 18-24.9, Mild to Moderate 25-30, Severe >30)				
<b>Skin Quality:</b> Fine lines, crepiness/wrinkling, and/or poor elasticity				
<b>Chest: Check the appropriate boxes</b>	<b>None</b>	<b>Mild</b>	<b>Moderate</b>	<b>Severe</b>
<b>Skin Laxity:</b> Laxity of chest tissues across upper-chest				
<b>Skin Quality:</b> 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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