truSculpt® iD

HEALTH HISTORY

PERSONAL INFORMATION

DATE: _____

LAST NAME: _____ FIRST: _____ M.I.: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

CELL: _____ EMAIL: _____

DATE OF BIRTH (MONTH/DAY/YEAR): _____ AGE: _____ SEX: ☐ FEMALE ☐ MALE

WHERE DID YOU HEAR ABOUT US: (Please be specific)

INTERNET: _____ REFERRAL: _____

ADVERTISEMENT: _____ IF SO WHERE: _____ OTHER: _____

I AM INTERESTED IN: (Please check all that apply)

- ☐ BOTOX
- ☐ FILLERS
- ☐ ROSACEA
- ☐ ACNE TREATMENTS
- ☐ FINE LINES/WRINKLES
- ☐ SUN DAMAGE
- ☐ CELLULITE REDUCTION
- ☐ SKIN TIGHTENING
- ☐ FAT REDUCTION
- ☐ TATTOO REMOVAL
- ☐ SKIN CARE ADVICE/PRODUCTS
- ☐ MICRODERMABRASION
- ☐ FACIAL/LEG VEIN TREATMENTS
- ☐ HAIR REMOVAL
- ☐ VAGINAL REJUVENATION

☐ OTHER, PLEASE SPECIFY _____

DO YOU USE SUNSCREEN? ☐ YES, IF YES SPF # _____ ☐ NO

WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

☐ ALWAYS BURN, NEVER TAN ☐ USUALLY BURN, TAN WITH DIFFICULTY ☐ SOMETIMES BURN, TAN ABOUT AVERAGE

☐ ALMOST NEVER BURN, TAN VERY EASILY ☐ RARELY BURN, TAN EASILY ☐ NEVER BURN, ALWAYS TAN

MEDICAL HISTORY: (Check the appropriate box next to any condition for which you have ever been treated)

- ☐ ACNE
- ☐ ARTHRITIS
- ☐ AUTOIMMUNE DISORDER
- ☐ BLOOD DISORDERS
- ☐ CANCER (OR RADIATION THERAPY)
- ☐ DIABETES / DIABETIC NEUROPATHY
- ☐ HERPES (OR COLD SORES)
- ☐ HIRSUTISM
- ☐ VITILIGO
- ☐ KIDNEY DISEASE
- ☐ MELANOMA
- ☐ PORT WINE STAIN
- ☐ PSORIASIS
- ☐ PACEMAKER
- ☐ SHINGLES
- ☐ SKIN PIGMENTATION
- ☐ STEROID OR HORMONAL THERAPY
- ☐ HORMONAL IMBALANCES
- ☐ POLYCYSTIC OVARIAN SYNDROME
- ☐ KELOID SCARS / OTHER SCARS

ADDITIONAL QUESTIONS:

1 ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? IF YES, PLEASE SPECIFY.

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2 ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL PREPARATIONS, MEDICAL PATCHES OR ASA? IF YES, PLEASE SPECIFY.

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3 DO YOU HAVE ANY ALLERGIES? IF YES, PLEASE SPECIFY.

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4 HAVE YOU EVER USED (OR ARE CURRENTLY USING) RETIN A OR GLYCOLIC ACID? IF YES, PLEASE SPECIFY.

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5 HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE? IF YES, PLEASE SPECIFY.

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6 HAVE YOU EVER HAD A CHEMICAL PEEL? IF YES, PLEASE SPECIFY.

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7 HAVE YOU HAD ANY LASER TREATMENTS? IF YES, PLEASE SPECIFY.

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8 WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

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9 DO YOU HAVE ANY DENTAL OR ACRYLIC IMPLANTS, CROWNS OR BRIDGEWORK? IF YES, PLEASE SPECIFY.

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10 DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? IF YES, PLEASE SPECIFY.

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11 DO YOU HAVE A PACEMAKER?

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12 HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE)?
IF YES, PLEASE SPECIFY.

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13 DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? IF SO, THEN HOW OFTEN?

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14 HAVE YOU EVER HAD GOLD THERAPY (USED FOR RHEUMATOID ARTHRITIS)?

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15 ARE YOU CURRENTLY PREGNANT?

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16 HAVE YOU HAD FILLER OR BOTOX/DYSPORT INJECTIONS IN THE AREA TO BE TREATED?
IF YES, PLEASE SPECIFY.

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17 DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES?

I permit photographs and digital images being taken to evaluate treatment effectiveness, for medical education and training. 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 without my permission.

I freely consent to the proposed treatment. I hereby release BEAUTILASE, from any liability arising out of the services associated with the above treatment. 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. All my questions have been answered. By signing below, I certify that I have read and fully understand this consent form as well as the Exclusionary Criteria listed.

I certify that the preceding medical, personal, and skin history are true and correct. I am aware of the above stated BEAUTILASE policies and will abide by them. I am aware that it is my responsibility to inform BEAUTILASE of any medical changes, health changes, skincare regime, new or changed medications, or recent sun exposure as this will alter the results of my treatment. A current medical history is essential for the caregiver to execute the appropriate treatment procedures.

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE TREATMENTS ARE NON REFUNDABLE AND NON EXCHANGEABLE. THIS INCLUDES ANY PACKAGE DEALS WE OFFER.

PLEASE SIGN BELOW TO INDICATE ALL THE INFORMATION ON THIS FORM IS ACCURATE AND COMPLETE.

SIGNATURE: _____ DATE: _____

CUTERA®
FACE + BODY AESTHETIC SOLUTIONS