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* ☐YES ☐NO
Severe or Cystic Acne in the treatment area* ☐YES ☐NO
Active implants (e.g., pacemakers or defibrillators), or metallic implants in the treatment area* ☐YES ☐NO
Hemorrhagic or bleeding disorders*** ☐YES ☐NO
Pregnant or lactating*** ☐YES ☐NO

Migraines*** ☐YES ☐NO
Bell's palsy*** ☐YES ☐NO
Active or local skin disease that may alter wound healing*** ☐YES ☐NO
Autoimmune Disease*** ☐YES ☐NO
Epilepsy*** ☐YES ☐NO
Herpes or Cold sores*** ☐YES ☐NO
Diabetes*** ☐YES ☐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

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

Treatment checklist

Pre-treatment photos taken…… ☐YES ☐NO
Procedure reviewed with patient: …… ☐YES ☐NO
Patient questions answered: …… ☐YES ☐NO
Informed Consent signed: …… ☐YES ☐NO
Photo Consent signed: …… ☐YES ☐NO
Ultherapy™ treatment date: _____
Pre-Medication Order: _____
Ultherapy® Treatment Record from System printed or Patient Record Completed: …… ☐YES ☐NO
"What to Expect" pamphlet instruction given to patient:…… ☐YES ☐NO

Follow up checklist

Aesthetic care plan discussed:_____
_____
3 month follow-up appointment scheduled:_____
Face/Neck:
1st follow-up visit date:_____ Photos Taken: ☐FV ☐R45 ☐R90 ☐L45 ☐L90
2nd follow-up visit date:_____ Photos Taken: ☐FV ☐R45 ☐R90 ☐L45 ☐L90
Décolleté:
1st follow-up visit date:_____ Photos Taken: ☐FV ☐R45 ☐R90 ☐L45 ☐L90
2nd follow-up visit date:_____ Photos Taken: ☐FV ☐R45 ☐R90 ☐L45 ☐L90

Clinical and treatment notes:

_____

_____

_____

_____

_____

_____

Ultherapist Signature: _____ Date:_____

Physician Signature: _____ Date:_____

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