

Ultherapy® Consult Record

Patient Name: _____

Date: _____

Medical and Surgical History

Age: ____ Weight: ____ lbs. Height: ____

Gender: M F

Active Severe or Cystic Facial Acne* YES NO
 Open facial wound or lesion* YES NO
 Metal stents in the treatment area** YES NO
 Implanted electrical devices** YES NO
 Pregnant or lactating*** YES NO
 Migraines*** YES NO
 Bell's palsy*** YES NO
 Hemorrhagic or bleeding disorders*** YES NO

Mechanical or other implants in the treatment area** 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: _____

Undergone the following cosmetic procedures in the brow or lower face and neck area:

Facial skin tightening procedure treatment within the last 1 year..... YES NO
 Treatment name: _____ Location treated: _____ Date of last treatment _____
Filler (i.e. Juvederm® or Sculptra®) within the last 3-6 months..... YES NO
 Product name: _____ Location treated: _____ Date of last treatment _____
Neurotoxin (i.e. Botox® or Dysport®) within the last 3-6 months..... YES NO
 Product name: _____ Location treated: _____ Date of last treatment _____
Ablative resurfacing laser treatment YES NO
 Treatment name: _____ Location treated: _____ Date of last treatment _____
Non - Ablative resurfacing laser treatment YES NO
 Treatment name: _____ Location treated: _____ Date of last treatment _____
Dermabrasion or deep facial peels..... YES NO
 Treatment name: _____ Location treated: _____ Date of last treatment _____
Lipoplasty in the face or neck regions..... YES NO
 Treatment name: _____ Location treated: _____ Date of last treatment _____
Facelift or blepharoplasty or brow lift..... YES NO
 Treatment name: _____ Location treated: _____ Date of last treatment _____

Are you currently taking the following prescription medications:

Accutane within the last 12 months..... YES NO
 Anticoagulants or antiplatelet drugs..... YES NO
 Immunosuppressant drugs..... 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 |
|------------|----------------|------|-----------|--------------|-----------------|
| | | | | | |
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*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

As every patient is different, the clinical factors listed below are intended to assist your clinician in forecasting your clinical response to Ultherapy. Please score each clinical factor listed below. Upon examination of your responses, your physician will discuss your options for achieving optimal results with Ultherapy.

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 box | None | Mild | Moderate | Severe |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|------|----------|--------|
| Skin Laxity: Excess skin or hooding on the eyelid; eyelid droopiness | | | | |
| Volume: Presence of fat deposits under eyes; infra-orbital puffiness | | | | |
| Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity | | | | |
| Clinical Response Factors – Lower face and neck: Check the appropriate box | None | Mild | Moderate | Severe |
| Skin Laxity: Descent of cheek tissue (hollowing mid cheek, jowling and/or submental laxity), downturn commissures, nasolabial folds, and/or draping of upper neck | | | | |
| Volume: Presence of fat deposits in lower face, loss of jaw definition, and/or excessive sub-Q fat | | | | |
| Skin Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity | | | | |

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: YES NO
Ultherapy® 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: _____
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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