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

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

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 Quality: Fine lines, crepiness/wrinkling, and/or poor elasticity				
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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F011-002 Rev:C

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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 ☐R90
2nd follow-up visit date:______ Photos Taken: ☐FV ☐R45 ☐R90 ☐L45 ☐R90

Clinical and treatment notes:

____

____

____

____

____

Ultherapist Signature: ______________________________________ Date:___________________

Physician Signature: ______________________________________ Date:___________________

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