Brinson Family Medicine
Ashton C. Brinson, MD

SCULPSURE® MEDICAL HISTORY FORM

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Date of Birth: _____ Sex: Female _____ Male _____

Family Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Which body area/areas would you like treated? _____

_____

_____

Please answer all of the following questions	**YES**	**NO**
1. Do you have **ANY** current or chronic medical illnesses? *Disclose any history of heat urticaria, diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, or <u>any</u> other condition or illness.*	☐	☐
Please List: _____		
2. Do you have **ANY** current or chronic skin conditions? *Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or <u>any</u> other skin condition.*	☐	☐
Please List: _____		
3. Are you currently under a doctor's care? If so, for what reason?	☐	☐
_____		
4. Do you take/use **ANY** medications (prescriptions and non-prescriptions), vitamins, herbal or natural supplements, on a regular or daily basis?	☐	☐
Please List: _____		
5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?	☐	
☐Please List: _____		

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6.	(For women) are you or could you be pregnant?	☐	☐
7.	Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)?	☐	☐
8.	Do you have **ANY** allergies to medications, foods, latex or other substances? Please List: _____	☐	☐
9.	Have you ever taken oral or injected gold therapy?	☐	☐
10.	Do you have a history of herpes I or II in the area to be treated?	☐	☐
11.	Do you have a history of keloid scarring or hypertrophic scar formation?	☐	☐
12.	Do you have a history of light induced seizures?	☐	☐
13.	Do you have any open sores or lesions?	☐	☐
14.	Do you have any history of radiation therapy in the area to be treated?	☐	☐
15.	In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood thinning medications? Please List product name and date last used: _____ _____	☐	☐
16.	Do you have a history of surgery or other treatments, medical or cosmetic, in the area to be treated? If yes, please list_____ _____	☐	☐
17.	Do you have or have you ever had a hernia?	☐	☐
18.	Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?	☐	☐
19.	Do you have a history of fainting or passing out?	☐	☐
20.	Do you consider yourself to have an anxious or nervous personality?	☐	☐
21.	Do you consider yourself claustrophobic or have issues with confinement?	☐	☐
22.	Have you had any unprotected sun exposure or used tanning beds or lamps in the last week?	☐	☐

Signature: _____Date: _____

Reviewed by:_____Date:_____

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INFORMED CONSENT FORM – SCULPSURE® BODY TREATMENT

The SculpSure® delivers laser energy to heat the deep layer of fat. The heat that is created damages the fat cells. The damaged fat cells are then eliminated by the body through your lymphatic system.

During the laser delivery the applicators cool the skin throughout the entire treatment. The cooling protects your skin while the energy heats your fat layer. When the treatment begins, it will feel warm, and over time the heat sensation will increase to short periods of intense deep heat. You may also experience some cramping, tingling, prickling or squeezing sensations deep in the fat layer. These sensations are normal and expected. These sensations indicate that the laser is effectively targeting and damaging the fat layer.

- For body areas (non-submental), the SculpSure is eye safe. There is no need to wear protective eyewear.
- Your skin may be slightly pink to red immediately after treatment. This may last for hours up to days.
- Following the SculpSure treatment you may experience swelling and tenderness that lasts approximately 2-3 (two to three) weeks, but may last longer. You may also experience tissue firmness or nodules. Nodules can last for days to several months, depending on the size of the nodule. This side effect typically resolves on its own. While uncommon, some nodules may be permanent.
- The treated areas should be massaged two (2) times a day for several minutes. For flank and abdomen treatments there are no lifestyle restrictions following your SculpSure treatment. For inner or outer thigh treatment it is recommended to avoid crossing your legs until any tenderness has resolved.
- Staying well hydrated and engaging in light physical activity helps mobilize the disrupted fat for processing through the lymphatic system. We encourage you to drink at least 8 (eight) glasses of water a day and take a daily walk or continue your regular exercise routine.
- You may use cold gel packs or Tylenol according to package instructions to help ease tenderness.

I understand that the practice of medicine is not an exact science and no results have been guaranteed. I acknowledge that the results may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized. ☐**Yes** ☐**No** **Initials: _____**

I have been informed that firmness, hardness, nodules, redness, tenderness, swelling, pain, and bruising, are the most common side effects. Other less common side effects which can occur are itching, skin contour irregularities, dimpling, hyperpigmentation/hypopigmentation, asymmetry, necrosis, changes in skin laxity, numbness, blister or burn. Rare occurrences of fainting or dizziness have been noted during and/or after the treatment. ☐**Yes** ☐**No** **Initials: _____**

I consent to photographs and digital images being taken and used to evaluate treatment effectiveness, for medical education, training, professional publications or sales and marketing purposes. 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 for such stated purposes without my permission. ☐**Yes** ☐**No** **Initials: _____**

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. ☐**Yes** ☐ **No** **Initials: _____**

I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered.

Consent for treatment of _____

Client:_____ Date _____

Witness:_____ Date _____

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Photographs Consent Form

I DO _____, DO NOT _____ (Please initial one) hereby authorize Brinson Family Medicine staff to take my photograph during my initial consultations, during, and at the end of my SculpSure® treatment. I understand that these pictures are for office purposes only, and are kept in my chart at all times.

I DO _____, DO NOT _____ (Please initial one) give permission for my photographs to be used by Brinson Family Medicine for marketing or educational purposes. I also understand that if used, these photographs will not contain my name or any other identifying information.

Patient: _____ Date: _____

Witness: _____ Date: _____