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	Mechanical or other implants in the treatment area**	☐YES ☐NO
Open facial wound or lesion*	☐YES ☐NO	Active or local skin disease that may alter wound healing***	☐YES ☐NO
Metal stents in the treatment area**	☐YES ☐NO	Autoimmune Disease***	☐YES ☐NO
Implanted electrical devices**	☐YES ☐NO	Epilepsy***	☐YES ☐NO
Pregnant or lactating***	☐YES ☐NO	Herpes or Cold sores***	☐YES ☐NO
Migraines***	☐YES ☐NO	Diabetes***	☐YES ☐NO
Bell's palsy***	☐YES ☐NO		
Hemorrhagic or bleeding disorders***	☐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