FURST MD
AESTHETICS

Tru Sculpt 3D Medical History Form

Name:_____ **Date of Birth**_____

Address_____

_____

City_____**State**_____**Zip Code**_____

Best Phone Number_____

Restrictions on contacting you? No Yes If yes please specify_____

Email_____

Relevant Medical History:

1. Are you allergic to any medications, latex, foods or other substances? YES* NO *If YES Please list:_____
   _____
2. Are you currently taking prescription, herbal, or over the counter medication? YES* NO *If YES Please explain:_____
   _____
3. List all past and current medical conditions._____
   _____
   _____
4. Have you had any surgeries? YES* NO *If YES Please list:_____
   _____
   _____
5. Do you have any metal in your body? YES* NO *If YES Please list and explain:
   _____
   _____
6. Are you currently pregnant or nursing? YES* NO

7. If you are a woman of childbearing potential are you using birth control? YES* NO* *Please explain:

_____

_____

8. Do you have a history of any skin disease or sensitivity? *If YES Please explain:_____

_____

9. Do you know your Skin Type? Fitz. Skin Type: I II III IV V VI

10. What is your daily intake of water (cups)? 0-2 2-4 4-6 6-8 more

11. Do you engage in any light physical activity such as walking? Check which best applies:

Never Rarely Sometimes Always

12. Do any of the discussed contraindications apply to you? YES* NO *If YES Please explain:_____

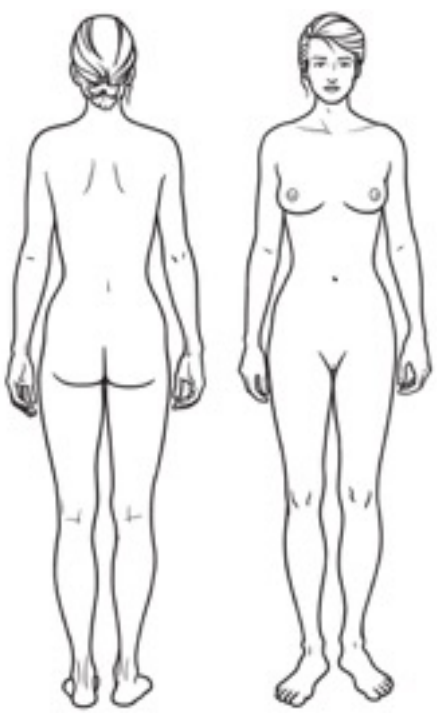
_____

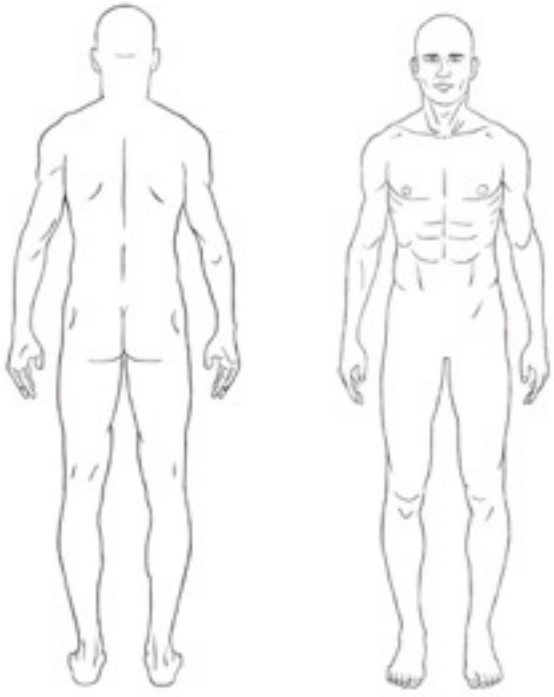
History:		**Yes**	**No**	**N/A**	**Date**
Recent Sun Exposure	X	X	X		_____
Previous Laser Treatments	X	X	X		_____
Hair Removal					
Waxing, Plucking, Electrolysis	X	X	X		_____
Accutane, last 6 months	X	X	X		_____
Gold Therapy	X	X	X		_____
Coagulopathies	X	X	X		_____
Herpes/Cold Sores	X	X	X		_____
Vitiligo	X	X	X		_____
History Melanoma	X	X	X		_____
Keloids/Hypertrophic Scarring	X	X	X		_____
Tattoos/Permanent Make-up	X	X	X		_____
Fillers, Botox etc.	X	X	X		_____
Pacemaker/Defibrillator	X	X	X		_____
Implants/Surgeries in treatment area	X	X	X		_____
Decreased sensation/Numbness in treatment area	X	X	X		_____

13. Which area(s) are you interested in receiving Tru Sculpt treatments? Please list and mark the areas on the diagram.

Mark area(s) on diagram:

N/A





N/A

Patient signature below indicates that the above information is accurate and current.

Patient signature:_____

Date:_____

Clinician signature:_____

Date:_____

Clinic Treatment Notes

Baseline Measurements: Date_____ Weight:_____Lbs
Circumference:_____CM

Initial:

_____ Benefits of procedure discussed
_____ Contraindications reviewed
_____ Risks reviewed
_____ Probability of success reviewed
_____ Alternative procedures available

_____ Consent signed
_____ Verbal and written post-treatment instructions given to patient
_____ Pre-op photos taken
Appointment scheduled: Date: ____/____/____

Comments:

Signature of Consultant: _____

Post Tx Measurements: Date_____ Weight:_____Lbs
Circumference:_____CM

Post Tx Measurements: Date_____ Weight:_____Lbs
Circumference:_____CM

Post Tx Measurements: Date_____ Weight:_____Lbs
Circumference:_____CM

Tru Sculpt 3D Informed and Consent

Area(s) to be treated:_____

1. I hereby authorize Furst MD Aesthetics to treat me using the Tru Sculpt system.
2. I understand the results may vary from person to person and that an exact result cannot be predicted.
3. I understand that completing a full treatment series, administered 7-14 days apart, is necessary to maximize treatment efficacy.

4. I understand that good dietary habits, sufficient intake of water and light physical activity are beneficial and may optimize results.
5. I understand there are certain risks associated with Tru Sculpt treatments and they include but are not limited to
    ~ Redness
    ~ Edema of the skin, subcutaneous fat, and muscle tissue due to excessive heating
    ~ Tissue tenderness
    ~ Bruising

    Although unlikely, adverse effects such as skin burns and blisters may occur due to excessive heating.
6. I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks.
7. I confirm that I do not have an inserted pacemaker, internal defibrillator, or metal implants. I am not pregnant or breastfeeding.
8. I have been advised to increase my water intake at least 24 hours before and after treatment. On the day of treatment, I will need to wear comfortable clothing and may have to remove all jewelry. The treatment area(s) will be exposed to various degrees of heat from the Tru Sculpt system. I may experience intense heat.
9. I agree to before and after treatment photographs, measurements, and weight as this will help in the evaluation of the results of the treatment.
10. I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure and possible side effects.

I hereby give my consent and authorization and release Furst MD Aesthetics and its Staff, of any claims that I have in the future connection with the described treatment.

SIGNATURE:_____DATE:_____

WITNESS:_____DATE:_____

Recommended Pre & Post Care for Tru Sculpt 3D Treatments

For best results please follow these instructions

Before your treatment:

- Excess hair may need to be shaved
- Notify clinic with any changes to your health history or medications since your last appointment

After your treatment:

- Tenderness, redness and swelling may occur and resolve within 24 hours
- Multiple treatments may be required
- Notify clinic if any of the following occur:

    - Blister, crusting or skin burns
    - Tenderness, redness or swelling persisting longer than 24 hours
    - Nodules or lumps in the treatment area
- May develop up to 72 hours post-treatment

- Additional instructions: _____

_____

If you have any questions, please contact us at: 703-941-9552.