AAC MEDICAL HISTORY FORM

VELASHAPE III TREATMENT

Name: _____ Date of Birth: / /

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____ How Referred: _____

Previous Treatments: Yes ☐ No ☐ If yes, date Last Treated: / / Area: _____

SKIN TYPE ASSESSMENT

Fitzpatrick Skin Type ☐ I ☐ II ☐ III ☐ IV ☐ V ☐ VI

Ethnicity _____ Degree of Cellulite _____

Height _____ Weight _____ BMI _____

MEDICAL HISTORY

Do you have any of the following?

- ☐ Pacemaker/Defibrillator
- ☐ Active skin infection (e.g. psoriasis, eczema)
- ☐ Metal Implants
- ☐ Skin disorders (e.g. keloids, abnormal wound healing)
- ☐ Current history of skin cancer/other cancer/pre-malignant moles
- ☐ History of bleeding disorders/use of anticoagulants
- ☐ Severe concurrent medical conditions (e.g. cardiac disorders)
- ☐ Use of medications/herbs including photosensitivity
- ☐ Pregnancy and nursing
- ☐ Edema due to lymphatic drainage problem
- ☐ Impaired immune system
- ☐ Varicose veins
- ☐ Diseases simulated by light (e.g. Lupus, Porphyria, Epilepsy)
- ☐ Tattoo or permanent makeup
- ☐ Diseases simulated by heat (e.g. Herpes Simplex)
- ☐ Tanned skin
- ☐ Endocrine disorders (e.g. diabetes, PCOS)
- ☐ Surgical procedures

List any medications taken _____

List any allergies _____

Detail any medical condition _____

_____

_____

Patient Name: _____ Signature: _____

Medical Director review date: _____ Medical Director Signature: _____

Anti-Aging Centers
laser hair removal, cosmetic skin rejuvenation & esthetics

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VELASHAPE III CONSENT & RELEASE

DESCRIPTION OF THE PROCEDURE

Velashape III is a new non-invasive treatment that uses a combination of technologies to contour your body and reduce the appearance of cellulite. Vacuum technology manipulates your skin while infrared light and bi-polar radio frequency energies gently heat fat cells and surrounding tissue.

CONTRAINDICATIONS

Treatment with this device is contra-indicated for patients with any of the following conditions:

- Pacemaker or internal defibrillator
- Superficial metal or other implants in the treatment area
- Current or history of skin cancer, or current condition of any other type of cancer, or pre-malignant moles
- History of any kind of cancer*
- Severe concurrent conditions, such as cardiac disorders.
- Pregnancy and nursing as well as 3-6 months post-childbirth or when the normal hormonal balance regained.
- Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications.*
- Diseases, which may be stimulated by light at the wavelengths used.
- Patients with history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area, may be treated only following a prophylactic regimen
- Poorly controlled endocrine disorders, such as Diabetes
- Any active condition in the treatment area, such as sores, Psoriasis, eczema, and rash
- History of skin disorders, keloids, abnormal wound healing, as well as very dry and fragile skin
- History of bleeding coagulopathies, or use of anticoagulants
- Use of medications, herbs, food supplements, and vitamins known to induce photosensitivity to light exposure at the wave lengths used, such as Isotretinoin (Accutane) within last 6 months, Tetracyclines, or St. John's Wort within the last two weeks.*
- Any surgical procedure in the treatment area within the last three months or before complete healing.
- Treating over tattoo or permanent makeup.
- Excessively tanned skin from sun, sun-beds or tanning creams within the last two weeks.
- As per the practitioner's discretion, refrain from treating any condition, which might make it unsafe for the patient.

POTENTIAL RISKS AND SIDE EFFECTS

Certain side effects may be experienced during treatment or shortly afterwards, usually as a result of improper use of the system. Although these side effects are rare and temporary, they should be reported immediately to a physician for proper treatment. These are the side effects that may appear in the treatment area:

- Pain
- Excessive skin redness (erythema)
- Damage to natural skin texture (crust, blister, burn)
- Bruising

**Although not recommended, these conditions may be treated at the discretion and under the full responsibility of the medical director/physician. In such a case, a small area should be treated and assessed a few days later to determine if the patient will tolerate the treatment without developing adverse effects.*

VELASHAPE III CONSENT & RELEASE CONT.

I understand that the VelaShape is a device used for improving the appearance of cellulite and reducing circumferences and that it may also be therapeutic for improving circulation and muscle aches in the treated areas. I understand there is a possibility of short-term effects such as discomfort, reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me _____ (patient's initials). I have also been advised of the Pre-and Post-treatment care which are as follows:

PRE-TREATMENT INSTRUCTIONS:

1. Avoid the sun for a minimum of 7 days before treatment
2. Hydrate, hydrate, hydrate! For maximum results, stay hydrated and drink the recommended 64oz of water per day to help move the lymph and achieve optimal results. The machine will not achieve the desired affect if the body is dehydated.

POST-TREATMENT INSTRUCTIONS:

1. Avoid the sun for a minimum of 7 days after treatment
2. Make a followup appointment within 1-2 weeks of treatment.
3. For maximum results, exercise for 30 mins a day to help move the lymph.
4. Follow up the VelaShape treatment with one of AAC's body treatment for lymphatic drainage.

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment.

I understand that treatment with the VelaShape involves a series of treatments and the fee structure has been fully explained to me _____ (patient's initials).

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

This consent form is valid until all or part is revoked by me in writing.

I _____ authorize Anti-Aging Centers of Connecticut LLC and its designated staff to perform VelaShape treatment on my body.

Client Signature: _____ Date _____

Parent signature for clients under 18 years of age: _____

Technician Signature: _____ Date _____