WHELIHAN LASER
6801 Lake Worth Rd., Suite 100W
Greenacres, FL 33467
(561) 795-4507

Patient Medical History – SmoothShapes® Treatments

Date ____________ Who may we thank for referring you? ____

Name ____ Date of Birth: ___________

Address ____ City/St _____________________ Zip ______

Phone: Home or work ___________________ Cell ________________________ Cell carrier _____________

Email Address: ____

Age _______ Sex _______ Marital Status (circle): Single / Married / Divorced / Widowed

Race: Caucasian ____ African American ____ Hispanic ____ Asian ____ Other _________________

Is your family aware of this treatment? __________ Social Security # ________________

How much time do you spend in the sun? ____

Do you go to a tanning booth? _________ How often? ____

Do you wear sunscreen? _________ How often? ________________________________ SPF? _________

What products are you currently using on your face/body?____

Do you exercise regularly? ________ If so, what and how often?_________________________________

Do you bruise easily? __________

Have you ever had any laser treatment? ______ Specify: ____

Date of last physical exam: ________________________

Are you currently being treated by a physician for any reason? _______ Specify: ________________________

____

List any medications you are currently taking (including over the counter medications, vitamins and herbal supplements: ____

List any medications you are allergic to: ____

Do you have a history of taking any of the following medications?

Testosterone ____ Chemotherapy ____ NSAIDS ____ Blood Thinners ____ Accutane ____

What areas of your body are you concerned with in regard to Cellulite? Rate 1 to 5 with 5 being most concerning.

Back of Thighs	1	2	3	4	5	Abdomen	1	2	3	4	5
Front of Thighs	1	2	3	4	5	Hips	1	2	3	4	5
Side of Thighs	1	2	3	4	5	Upper back	1	2	3	4	5
Buttocks	1	2	3	4	5	Other _____________________	1	2	3	4	5

GENERAL MEDICAL HISTORY - Do you have or have you ever had diseases or conditions of:

Acne	____	Hemophilia	____
Cancer	____	Hepatitis	____
Cold Sores	____	H.I.V.	____
Fever Blisters	____	Keloid Scars	____
Dermatitis/Eczema	____	Moles	____
Diabetes	____	Bleeding Disorders	____
Genital Herpes	____	Problems with Healing	____
Tattoo	____	Allergies:	
Shingles	____	Drug	____
Heart Condition	____	Environmental	____
Herpes Type I/II	____	Latex	____
Asthma	____	Breathing Problems	____
Chest Pains	____	Circulatory Problems	____
Tuberculosis	____	Chemo / Radiation	____
Epilepsy	____	High Blood Pressure	____
Skin Allergies	____	Psoriasis	____
Vitiligo	____	Metal Plates	____
Seizures	____	Blood Diseases	____
Blood Transfusions	____	Malignancies	____

Comments on any of the above: ____

____

Please circle the areas you are interested in having treated for cellulite reduction or pain management (today and in the future):

Front of Thighs   Back of Thighs   Side of Thighs   Abdomen   Hips

Upper Arms   Buttocks   Lower Back   Upper Back

Shoulders   Calves   Knees   Other ___________________

Do you have any interest now or in the future in Laser Treatments to improve the appearance of:

Surgical scars   Acne scars   Other scars   Stretch marks   Fine lines & wrinkles

Facial Veins   Rosacea   Skin pigmentation & Sunspots   Photofacials   Hair Removal

FEMALES ONLY:

Are you pregnant? ________ When was your last menstrual cycle? __________________________________
Do you have menstrual irregularities? ____
Have you experienced fertility problems? ____
Are you taking hormone supplements? ____

I understand that health information is important for safe and effective laser treatment. I acknowledge that all information given is truthful, complete and accurate to the best of my knowledge and I agree to update you, throughout the treatment process, of any changes in my health assessment, changes in medications and physical conditions.

_________________________________   ________
Patient Signature   Date

_________________________________   ________
Parent/Guardian Signature of minor   Date

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CONSENT FOR SMOOTHSHAPES® XV TREATMENTS

I authorize SmoothShapes® Laser treatments to be performed on me. I understand that the procedure is purely elective.

I understand that common side effects may include redness, mild tingling, increased urination, bruising, skin tenderness, skin abrasion, warming of the feet, which may last a few hours to 3-4 days or longer and failure to achieve the desired result. I may experience other unknown side effects that have not been reported before. Lasers can cause eye injury and protective eyewear must be worn during treatment. Serious complications are rare, but possible.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education training, professional publications or sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

Before and after treatment instructions have been discussed with me. The procedure as well as alternative treatment, potential benefits and risks have been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment as well as for future treatments as needed.

Signature: ____ Date _____________

Print name: ____

Witness signature: _________________________________ Date: ____________

Print name: _____________________________

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Patients of Dr. Whelihan, M.D.

"Under Florida law, Physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. DR. WHELIHAN HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against non-insured Physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law".

____

Patient (or legal guardian) Signature

____

Date

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SmoothShapes® - Skin Care Instructions
(Keep this page)

Pretreatment Instructions

General Instructions:

- Treatment areas should be clean and free from any topical lotions, oils or moisturizers.
- Do not use tanning cream 1-2 days before treating so that the tanning cream residue is minimized.

Post Treatment Instructions

General Instructions:

- Drink 6-8 glasses of water the day of the treatment.
- Be sure that your next treatment is scheduled.

Most side effects resolve within minutes and usually no longer than 2-3 hours.

- A mild tingling, warmth or redness may be present immediately post treatment.
- You may experience increased urination the day of treatment.
- If you have had treatment over a pre-existing bruise, the bruise may temporarily increase in size, but will resolve over time.

Post treatment skin care instructions must be followed ensure the best possible outcome. Please contact the office at 561-795-4507 with any questions or concerns regarding your treatment.