

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

Patient Medical History – Face and/or Skin Tightening Treatments

Name: _____ Referred by: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Cell: _____ Work: _____ Home: _____

Date of Birth: _____ Age: _____ Sex: Female _____ Male _____

Email: _____

How much time do you spend in the sun? _____

Do you wear sunscreen? _____ How often? _____ what SPF? _____

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

Have you ever had any laser treatment? _____ Specify: _____

Emergency Contact: _____ Phone: _____

Please answer all of the following questions:

YES NO

1. Do you have **ANY** current or chronic medical illnesses? YES NO

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 any other condition or illness.

Please List: _____

2. Do you have **ANY** current or chronic skin conditions? YES NO

Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or any other skin condition.

Please List: _____

3. Are you currently under a doctor's care? If so, for what reason? YES NO

4. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? YES NO

Please List: _____

YES NO

5. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? YES NO

Please List: _____

6. Do you take/use ANY systemic/oral steroids (e.g., prednisone, dexamethasone)? YES NO

7. Do you have any allergy to corn or to gold? YES NO

8. Do you have a pacemaker or defibrillator (ICD)? YES NO

9. Do you have metal implants in the treatment area **OR** anywhere in your body? YES NO

Please list: _____

10. Do you have **ANY** allergies to medications, foods, latex or other substances? YES NO

Please List: _____

11. (For women) are you or could you be pregnant or are you breastfeeding? YES NO

12. Do you have a history of herpes I or II in the area to be treated? YES NO

13. Do you have a history of keloid scarring or hypertrophic scar formation? YES NO

14. Do you have a history of light induced seizures? YES NO

15. Do you have any open sores or lesions in the area(s) to be treated? YES NO

16. Do you have any history of radiation therapy in the area to be treated? YES NO

17. 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? YES NO

Please List product name and date last used: _____

18. In the last three (3) months, have you used any of the following products: glycolic acid or other alphahydroxy or betahydroxy acid products; exfoliating or resurfacing products or treatments? YES NO

Please List product name and date last used: _____

19. Do you have or have you ever had any permanent make-up, tattoos, implants, or fillers, including, but not limited to, collagen, autologous fat, Restylane®, etc.? YES NO

If yes, please list locations on or in the body and dates last used _____

20. Do you have or have you ever had any Botulinums, such as Botox®, Xeomin or Dysport®? YES NO

If yes, please list locations on or in the body and dates last used _____

21. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? YES NO

22. Have you taken Tretinoin (like Retin-A®, Renova®) in the last 3 months? YES NO

23. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks? YES NO

Signature: _____ Date: _____

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Informed Consent for TempSure™ Wrinkle, Tissue Heating, and Cellulite Treatments

As a client, it is important for you to understand the expected results and risks of radiofrequency skin treatment with the TempSure System. Please read this document carefully. Before signing this document, please ask your practitioner providing the RF treatment, about any aspect of this document, or the procedure, that you do not understand.

TempSure System equipment may present a hazard to clients with implanted devices or pacemakers. Please consult qualified medical personnel prior to being treated with radiofrequency equipment.

Since ongoing feedback by a client during a procedure is required, if you have nerve insensitivity to heat anywhere in the treatment area, you should not be treated with the TempSure System.

Inadequate or impaired feedback may lead to burns or injury. Ongoing feedback should be provided by you to the individual performing the treatment to avoid excessive discomfort.

TempSure System treatments have not been studied for use on pregnant clients, clients with autoimmune disease, diabetes, or herpes simplex.

TempSure System has been cleared by the FDA for the following:

NOTE: All clients are different and exact results of this cosmetic procedure and treatments cannot be predicted or guaranteed.

- Non-ablative treatment of mild to moderate facial wrinkles and rhytids.
- Elevating tissue temperature for selected medical conditions such as temporary relief of pain, muscle spasms, and increase in local circulation.
- Temporary reduction in the appearance of cellulite.

During Treatment

You may feel an electric shock similar to a static discharge in a dry environment when the electrode makes contact or is removed from the skin. A common comparison is the static shock you might feel when touching something after dragging your feet across carpeting. Beard stubble should be thoroughly removed prior to treatment as remaining stubble may accentuate shocks. If the eyelids are to be treated directly, you will have plastic, non-conductive eye shields covering your eyes.

All jewelry and makeup, including lotions, eyeliner and eye shadow should be removed from the treatment area prior to treatment.

Wrinkles on cut, wounded or infected skin should not be treated as this could promote infection and injury.

Slight discomfort may be experienced while undergoing treatment. Typically, the discomfort is mild and temporary during the procedure and localized within the treatment area. During the treatment you should feel warmth and heat and provide ongoing feedback to the individual performing the treatment. Therefore, no anesthetic (local, oral, or systemic) should be used prior to or during the treatment.

After Treatment

Studies indicate the possible side effects of TempSure System are usually treatment-site related and include mild discomfort during the procedure localized within the treatment area. Mild swelling and redness may occur which typically goes away within 2 to 24 hours.

Diligent protection from sun exposure and application of sunscreen for two to three weeks after treatment will minimize pigmentation changes.

A regimen to moisturize and soothe skin for one-week post-treatment is recommended.

There is the possibility that additional risk factors of radiofrequency skin treatments may be discovered. The results of performing RF wrinkle treatments in combination with other treatments is unstudied and unknown.

It has been explained to me that this is a cosmetic procedure and not covered by insurance. It has been explained to me that more than one treatment may be recommended to achieve the best results and that there are other treatment options such as microdermabrasion, chemical peels, filler injections, or no treatment at all. As mentioned before, results will vary from one patient to the next and there is no guarantee of results.

My signature below signifies that all of my questions have been answered by the treatment provider or consultant. I understand the risks, complications, expected results, and expense of the treatments. I have read and understand this document and give my consent to receive treatment with the TempSure System.

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

I freely consent to the proposed treatment today as well as for future treatments as needed.

Client Name _____

Signature _____

Date _____

Practitioner Name _____

Signature _____

Date _____

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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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Pre-Treatment & Post-Treatment Instructions
Tempsure Face / Neck Tightening Treatments

Pre-Treatment:

- Remove all makeup, including eye makeup, lotions or sun block and wash facial and neck area prior to treatment. Any preparations left on the skin will act as impedance to the energy and will diminish the effects.
- Neurotoxins or fillers should be given post-treatment or a minimum of two weeks prior to the TempSure Treatment.
- For one to two weeks prior to treatment, at the practitioner's discretion, avoid therapies that may cause erythema (redness) or irritation such as Retin-A or products containing Isotretinoin, Retinol, glycolic and/or salicylic acid.
- The treatment area must be free of any open lesions or infections.
- For an optimum treatment, hydrate by drinking plenty of water or hydrating fluids several days in advance. Avoid alcohol if possible.

Post-Treatment:

Typically, clients may return to their normal activities after receiving a TempSure treatment. Please follow the advice of the practitioner regarding the care of your skin.

- Wash skin with tepid water and a gentle cleanser.
- If the skin is slightly pink or red in areas following the treatment, avoid hot water when washing or showering until any erythema (redness) has subsided.
- Makeup, preferably mineral-based, may be applied immediately post treatment.
- Soothing creams or moisturizers may be used.
- Use a sun block with an SPF of 30 or greater if going out into the sun to help prevent future sun damage. This treatment does not cause photosensitivity.

The practitioner will describe the nature and timing of skin improvement that may be noticed over time. If there are any further questions or concerns, contact the treatment providers office.

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Pre-Treatment & Post-Treatment Instructions **Tempsure Body / Cellulite Treatments**

Pre-Treatment:

- Shave any dense hair on area to be treated.
- Do not wear constrictive clothing. Treatment area must be accessible and a secondary area for the Neutral Pad will also need to be accessed.
- The treatment area must be free of any open lesions or infections.
- Remove any lotions, moisturizers or other products from the treatment area.
- For an optimum treatment, hydrate by drinking water or hydrating fluids several days in preparation. Avoid alcohol if possible.

Post-Treatment:

- The client may return to normal activity after treatment.
- If skin is slightly pink or red, avoid hot water until subsided.
- Soothing non-irritating moisturizers may be used.
- Use sun block with UVA and UVB protection with SPF 30 or greater to prevent sun damage.
- It is recommended to maintain weight. Gaining excess weight will compromise treatments.
- Exercise will enhance your results. Always check with your practitioner prior to starting any exercise program.
- Treatments must be given at the suggested intervals to obtain optimal results.
- Maintenance treatments are recommended every six months.