CYNOSURE
Pellevé™

Swansea Rd Clinic
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Victoria, 3765
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Date: _____

MEDICAL HISTORY FORM

Last Name: _____ First Name: _____ Sex: (Male) or (Female)

Address: _____

City: _____ State: _____ Post Code: _____

Telephone
(Home): _____ (Mobile): _____ (Work): _____

Date of Birth: _____

Family Doctor: _____ Phone: _____

Emergency
Contact: _____ Phone: _____

Which body area/areas or condition would you like treated? _____

_____

_____

Please answer all of the following questions:	**YES**	**NO**
1. Do you have **ANY** current or chronic medical illnesses? *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? *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?	☐	☐
4. Do you take/use **ANY** medications (prescriptions and nonprescriptions), vitamins, herbal or natural supplements, on a regular or daily basis? Please List: _____	☐	☐
5. Are there **ANY** topical products (both medical and non-medical) that you use on your skin on a regular or daily basis? Please List: _____	☐	☐
6. Do you take/use **ANY** systemic/oral steroids (e.g., prednisone, dexamethasone)?	☐	☐
7. Do you have **ANY** allergies to medications, foods, latex or other substances? Please List: _____	☐	☐
	YES	**NO**

8. Are you receiving or have you received gold therapy? (rheumatoid arthritis) ☐ ☐

9. (For women) are you or could you be pregnant? ☐ ☐

10. (For women) are your menstrual periods regular? ☐ ☐

11. (For women) have you ever been diagnosed with Polycystic Ovarian Disorder? ☐ ☐

12. Do you have a history of **Herpes** I or II in the area to be treated? ☐ ☐

13. Do you have a history of **Keloid** scarring or **Hypertrophic** scar formation? ☐ ☐

14. Do you have a history of light induced **Seizures**? ☐ ☐

15. Do you have **ANY** open sores or lesions? ☐ ☐

16. Do you have **ANY** history of radiation therapy in the area to be treated? ☐ ☐

17. In the last six (6) months, have you used **ANY** of the following:
   - anticoagulants or blood-thinning medications; ☐ ☐
   - photosensitizing medications; ☐ ☐
   - anti-inflammatory medications ☐ ☐

   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 salicylic acid; ☐ ☐
   - alphahydroxy or betahydroxy acid products; ☐ ☐

   Please List product name and date last used: _____

19. In the last three (3) months, have you used **ANY** exfoliating or resurfacing products or treatments? ☐ ☐
   Please List product name and date last used: _____

20. 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.? ☐ ☐
   If yes, please list locations on or in the body and dates: _____

21. Do you have or have you ever had **ANY** Botulinums, such as Botox® or Dysport®? ☐ ☐
   If yes, please list locations on or in the body and dates: _____

22. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months? ☐ ☐

23. Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months? ☐ ☐

24. 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? ☐ ☐

Signature: _____ **Date:** _____

Patient Name: _____ Date: _____

As a patient, it is important for you to understand the expected results and risks of radiofrequency skin treatment with the Ellman International Pellevé™ Wrinkle Reduction System. Please read this document carefully. Before signing this document, please ask your physician, or the consultant providing the Pellevé™ treatment, about any aspect of this document, or the Pellevé™ procedure, that you do not understand.

Pellevé™ Wrinkle Reduction System equipment may present a hazard to patients with implantable devices or pacemakers. Please consult qualified medical personnel prior to being treated with radiofrequency equipment.

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

Pellevé™ Wrinkle Reduction System for wrinkle treatment uses the Surgitron® Dual RF™ S5 equipment and is unstudied and unknown for pregnant patients, patients with autoimmune disease, diabetes, or herpes simplex.

Pellevé™ System

Ellman's Pellevé™ Wrinkle Reduction System has been cleared by the FDA for the nonablative treatment of mild to moderate facial wrinkles and rhytids on skin photoypes I-IV. All patients are different and exact results of this cosmetic procedure and treatments cannot be predicted or guaranteed. Our studies indicate that greater than 85% of patients still have observable results six months after treatment.

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, please have plastic, non-conductive eyeshields 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 anaesthetic (local, oral, or systemic) should be used prior to or during the treatment. Additionally, if you have nerve insensitivity to heat anywhere in the treatment area, you should

not be treated. 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.

After Treatment

Studies indicate the possible side effects of Pellevé™ 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 Pellevé™ 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, there is no guarantee of results and no refund of payments for the procedure will be made.

My signature below signifies that all of my questions have been answered by the physician 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 Pellevé™ Wrinkle Reduction System.

Patient Name_____ Signature_____

Date_____

Physician Name_____ Signature_____

Date_____