

## Medical History

Name \_\_\_\_\_

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Age \_\_\_\_\_ Referred by \_\_\_\_\_

Have you ever had the following?

- Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions such as multiple dysplastic nevi.
- Any active infection.
- Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
- Use of photosensitive medication and/or herbs that may cause sensitivity to 515 - 1200 nm light exposure, such as Isotretinoin, tetracycline, or St. John's Wort.
- Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications.
- Patient history of Hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control.
- History of bleeding coagulopathies, or use of anticoagulants
- History of keloid scarring.
- Very dry skin.
- Exposure to sun or artificial tanning during the 3–4 weeks prior to treatment.

Are you pregnant? \_\_\_\_\_

What medications are you taking (including aspirin)? \_\_\_\_\_

Daily consumption of alcohol \_\_\_\_\_

Allergies: \_\_\_\_\_

Are you taking any herbal preparations? (St. John's Wort, etc.) \_\_\_\_\_

If yes, list \_\_\_\_\_

Do you wear contact lenses? \_\_\_\_\_

Skin type (when exposed to the sun **without protection** for about 1 hour)

- always burns, never tans \_\_\_\_\_
- always burns, sometimes tans \_\_\_\_\_
- sometimes burns, sometimes tans \_\_\_\_\_
- always tans \_\_\_\_\_
- Hispanic, Asian, Mediterranean, Middle Eastern \_\_\_\_\_
- Black \_\_\_\_\_

When were you last exposed to the sun (including tanning booth)? \_\_\_\_\_

Do you use chemical sun tanning lotions? \_\_\_\_\_

Are you In-service a holiday in the sun? \_\_\_\_\_

Reason for visit (area to be treated) \_\_\_\_\_

Prior treatment (if any) \_\_\_\_\_

**Accent XL Informed Consent Form**

I understand that the Accent XL is a radio-frequency device (RF) device intended for use in dermatologic and general surgical procedures for non-invasive treatment of wrinkles, rhytides, cellulite & fat reduction. I understand that multiple treatments may be required and that there is no guarantee that the wrinkles/rhytides/cellulite/fat will be completely removed. I understand that there is a possibility of short term (few seconds to hours) adverse effects such as heating sensation, erythema and dry skin. Burns may occur in rare situations. These possible adverse effects have all been fully explained to me \_\_\_\_\_ (please initial).

I understand that the treatment by the Accent XL system involves a series of treatments and the fee structure has been fully explained to me.

I also understand that there are other options for wrinkles, rhytides, cellulite & fat reduction treatment that are available and each of these other options have fully been explained to me \_\_\_\_\_ (please initial).

With this in mind, I am choosing to try Accent XL non-invasive treatment for wrinkles, rhytides, cellulite & fat reduction.

**PHOTOGRAPHS :** I do \_\_\_\_ do not \_\_\_\_ give permission for photographs and other audio-visual and graphic materials to be used for marketing, education-promotion purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos.

Signature \_\_\_\_\_

I have read and understand this agreement and all my questions have been addressed and answered to my satisfaction. I agree to the terms of this agreement.

Patient's Name: \_\_\_\_\_

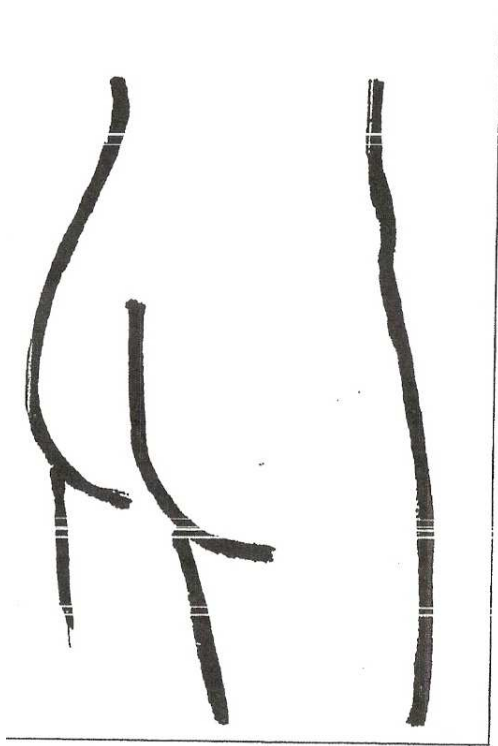
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

## ACCENT TREATMENT NOTES

NAME \_\_\_\_\_  
 B/P \_\_\_\_\_ TEMP \_\_\_\_\_ WGT \_\_\_\_\_  
 Measurements: A \_\_\_\_\_ B \_\_\_\_\_ R)C \_\_\_\_\_ L)C \_\_\_\_\_ R)D \_\_\_\_\_ L)D \_\_\_\_\_  
 R)E \_\_\_\_\_ L)E \_\_\_\_\_



Notes: remove jewelry & makeup, photo, measurements, empty bladder, consents, avoid tattoos, shave excessive hair

DATE	TREATMENT TIME	UNIPOLAR	BIPOLAR	#PASS	WATTS	TEMP
	60second passes/face					
PASS #1						
PASS#2						
PASS#3						
PASS#4						

Erythema: Light; Moderate: Severe

Toleration Scale:

1-cool 2-some warmth 3-warm, but comfortable 4-uncomfortable 5- unable to tolerate

NOTES: \_\_\_\_\_

\_\_\_\_\_

Technician signature \_\_\_\_\_

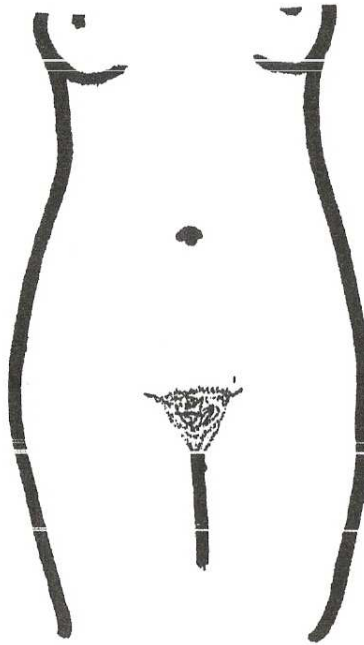
## ACCENT TREATMENT NOTES

NAME \_\_\_\_\_

B/P \_\_\_\_\_ TEMP \_\_\_\_\_ WGT \_\_\_\_\_

Measurements: A \_\_\_\_\_ B \_\_\_\_\_ (measure 2' above the umbilicus and 2' below)

**ABDOMEN**



Notes: remove jewelry & makeup, take photo, measurements, empty bladder, consents signed, avoid tattoos, shave excessive hair

DATE	TREATMENT TIME	UNIPOLAR	BIPOLAR	#PASS	WATTS	TEMP
	60second passes/body					
PASS #1						
PASS#2						
PASS#3						
PASS#4						

Erythema: (1) Light;(2) Moderate: (3) Severe

Toleration Scale:

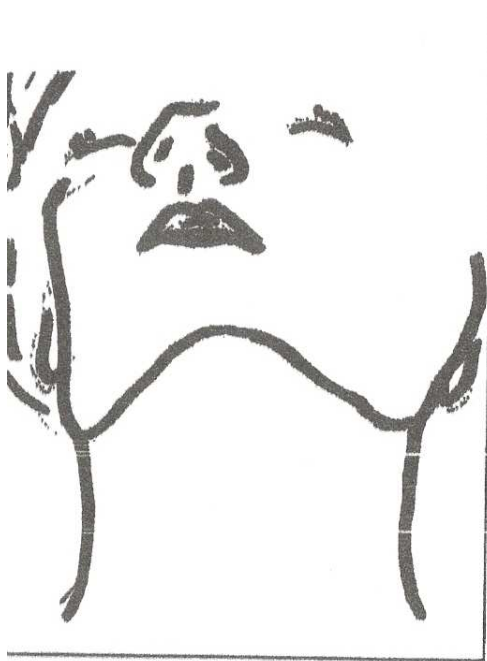
1-cool 2-some warm 3-warm, but comfortable 4-uncomfortable 5- unable to tolerate

NOTES: \_\_\_\_\_

Technician signature \_\_\_\_\_

# ACCENT XL TREATMENT NOTES

NAME \_\_\_\_\_  
 B/P \_\_\_\_\_ TEMP \_\_\_\_\_ WGT \_\_\_\_\_



Notes: remove jewelry & makeup, photo, measurements, empty bladder, consents, avoid tattoos, and thyroid

DATE	TREATMENT TIME	UNIPOLAR	BIPOLAR	#PASS	WATTS	TEMP
	30second passes/face					
PASS #1						
PASS#2						
PASS#3						
PASS#4						

Erythema: Light; Moderate: Severe

Toleration Scale:

1-cool 2-some warmth 3-warm, but comfortable 4-uncomfortable 5- unable to tolerate

NOTES: \_\_\_\_\_

\_\_\_\_\_

Technician signature \_\_\_\_\_

## Follow-Up

### Five point improvement scale

1. No improvement            2. 0-25% improvement            3. 25-50% improvement  
4. 50-75% improvement      5. 75-100% improvement

Follow-Up		5 Point Improvement Scale (Circle one option)				
After 4 weeks	FU #1 DATE	1	2	3	4	5
	___/___/___	1	2	3	4	5
After 8 weeks	FU #2 DATE	1	2	3	4	5
	___/___/___	1	2	3	4	5
After 12 weeks	FU #3 DATE	1	2	3	4	5
	___/___/___	1	2	3	4	5

Signature \_\_\_\_\_  
Date \_\_\_\_\_

## Follow-Up

### 5 point improvement scale

1. No improvement      2. 0-25% improvement      3. 25-50% improvement  
 4. 50-75% improvement      5. 75-100% improvement

<b>Follow-Up</b>		<b>5 Point Improvement Scale (Circle one option)</b>				
<b>After 16 weeks</b>	FU #1 DATE ____/____/____	1	2	3	4	5
<b>3 months after last treatment</b>	FU #2 DATE ____/____/____	1	2	3	4	5
<b>6 months after last treatment</b>	FU #3 DATE ____/____/____	1	2	3	4	5

Signature \_\_\_\_\_

Date \_\_\_\_\_

### Patient's Assessment of Results

3 month (post treatments) -----

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#### Patient to read and complete this section:

1. Describe your level of satisfaction so far with the results of the procedure (check the appropriate box):

- Most satisfied
- Satisfied
- Indifferent
- Not satisfied
- Disappointed

2. Describe the level of change in your appearance after the procedure (check the appropriate box):

- No Improvement
- 0 – 25% Improvement
- 25 – 50% Improvement
- 50 – 75% Improvement
- 75 – 100% Improvement

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient's Assessment of Results

6 month (post treatments) -----

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### Patient to read and complete this section:

1. Describe your level of satisfaction so far with the results of the procedure (check the appropriate box):

- Most satisfied
- Satisfied
- Indifferent
- Not satisfied
- Disappointed

2. Describe the level of change in your appearance after the procedure (check the appropriate box):

- No Improvement
- 0 – 25% Improvement
- 25 – 50% Improvement
- 50 – 75% Improvement
- 75 – 100% Improvement

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Contraindications**

- History of any skin malignancy
- Chronic skin conditions / irritated skin (i.e., Urticaria)
- History of cancer
- Pregnancy (including IVF)
- Active collagen or vascular disease
- High blood pressure
- Phlebitis and blood-clotting (hematology-related)
- Recent (less than one year) use of Isotretinoin (Accutane)
- Implantable pacemaker or automatic defibrillator/ cardioverter (AICD)
- Past or present of autoimmune illness or disorder
- Large dental metallic prosthetic implants
- Multi systemic diseases (diabetes, hypertension, coronary artery disease, renal insufficiency etc.)

## **Special Considerations**

- Smoking
- Alcohol consumption
- Dental metallic structure (i.e., bridge)
- Recent surgical procedures
- On-going medications

## **Patient Instructions**

### **Post-Treatment**

- Gently clean the treatment oil from the skin surface and dry it.
- Patient should drink two glasses of water immediately after the treatment.
- It is recommended to drink a lot of water (at least 8-10 cups a day) for three days following the treatment.
- It is recommended not to wash the face with hot water for 24 hours after treatment.
- It is recommended to avoid excessive exercise, sweating, hot baths or saunas for three days after the treatment.
- It is recommended to avoid consumption of alcoholic drinks for three days after treatment (alcohol might drain water from the body and skin).
- In order to maintain the treatment results, it is highly recommended to apply a moisturizing cream to the treatment area every day.

### **Follow-Up**

Measures presented below are only the manufacturer's recommendations for follow-up. They may serve as a basis for defining your treatment regimen.

- Daily skin hydration with a moisturizing cream
- Patient should drink plenty of fluids for 2-3 days after the treatment.
- Make-up can be applied 2 hours after the treatment
- Repeat the treatment every 2 weeks
- Treatment is complete when satisfactory results are obtained
- The number of treatment may vary according to the degree of skin irregularity, patient age, skin condition, smoking history, medical history and medications etc.