PEAR TREE
MEDICAL CLINIC P.C.

30-SECOND QUESTIONNAIRE

COSMETIC MEDICAL TREATMENTS

Please take a few moments to answer the questions below. Let us know if we can answer questions on your visit with us today about any of these new elective procedures that we are offering here at Pear Tree Medical Center! Thanks!

Would you be interested in improving unsightly spider veins? Yes____ No____

Would you be interested in a Medically Administered Weight Loss Program?

Yes____ No____

Which of these components are most important to you? How much would you like to lose? _____lbs

___ injectables

___ medications

___dietary consultations

___ meal replacement programs (MEDIFAST*Provider)

___ regular or weekly weight analysis

___ dietary journals

___ behavioral consultations and lifestyle modifications

Would you like to minimize pocket areas of fat such as “muffin top”, love handles” inner or outer thighs, back or bra fat or arms in 2 treatments? We have TruSculpt Body Sculpting here!

Yes ___ No___

Name _____

Cell Phone _____

Email _____

Zip code: _____

After completing, please return to the Front Desk. Thank you!

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Name: Dates i	Occupation:
Address: Phone:	Date of Birth:
City: State: Zip Code:	Email:
Cell: Phone: Contact me by __Text Cell	Emergency Contact:
How did you hear about us:	Referral Name:

General Health

1. Rate your level of stress: (5 = highest, 1= lowest) 5 4 3 2 1
2. Are you pregnant or nursing? Yes No
3. Do you wear contact lenses? Yes No
4. Do you smoke? Yes No How many cigarettes per day?
5. Please list any accidents or surgeries in the last 9 months:
6. Do you have any metal implants, a pacemaker or body piercings?
7. List the medications you are currently taking:

Prescription	Over the Counter

Health History

Heart Condition	Lymph Edema	Herpes/Shingles	High Blood Pressure	Low
Numbness/Tingling	Sinus Problems	Allergies	Chronic Pain	
Rashes	Jaw Pain/TMJ	Blood Clots	Constipation	
Diabetes	Gas/Bloating	Headaches	Arthritis	
Broken/Fractured Bones	Pregnancy (___ weeks)	Fatigue/Sleep Disorder	Depression/Anxiety	

Other (explain): Undergoing Cancer treatment

Skin Care

1. Are you under the care of a dermatologist? Yes No
2. Do you use: Accutane Retin A Renova Adapalene Other prescription skin products _____
3. Have you had a: Chemical Peel Microdermabrasion Botox Other resurfacing treatments
4. Are you currently using any products that contain: Glycolic Acid Lactic Acid Hydroxy Acid Vitamin A
5. Do you have any skin sensitivities or irritants

Skin Maintenance

51863 Schoenherr Road | Suite 101 | Shelby Township, MI 48315 | 586-991-0903 |
www.peartreemedicalclinic.com

Products You Use: Masque	Soap	Cleanser	Toner	Moisturizer	Exfoliator
Skin Type:	Oily/Congested	Dry/Dehydrated	Sensitive/Redness	Acne	Sunburned
Eczema	Claustrophobia	Psoriasis	Iodine or Shellfish		
Have you been tanning in the last 24 hours? Yes No		Are you going or coming from a vacation? Yes No			
What are your skin care goals?					

It is my choice to receive these Services from Pear Tree Medical Clinic. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update the staff at Pear Tree Medical Clinic of any changes to my health status. I understand that the staff at Pear Tree Medical Clinic, do not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments, pharmaceuticals, or perform spinal manipulations. I acknowledge that these treatments are not a substitute for medical examination or diagnosis, and that is recommended I see a primary health care provider for that service. If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24hour notice, I agree to pay the missed appointment fee that applies.

Name

Date

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Occupational Health Services

Tru Sculpt Medical History Form

Name:_____ **Date of Birth**_____

Adress_____

_____

City_____**State**_____**Zip Code**_____

Best Phone Number_____

Restrictions on contacting you? No ☐ Yes ☐ If yes please specify_____

Email_____

Relevant Medical History:

1. Are you allergic to any medications, latex, foods or other substances? ☐ YES* ☐ NO *If YES Please list:_____

   _____

2. Are you currently taking prescription, herbal, or over the counter medication? ☐ YES* ☐ NO *If YES Please explain:_____

   _____

3. List all past and current medical conditions._____

   _____

   _____

4. Have you had any surgeries? ☐ YES* ☐ NO *If YES Please list:_____

   _____

   _____

5. Do you have any metal in your body? ☐ YES* ☐ NO *If YES Please list and explain:

   _____

   _____

6. Are you currently pregnant or nursing? ☐ YES* ☐ NO

7. If you are a woman of childbearing potential are you using birth control? ☐ YES* ☐ NO*
   *Please explain:
   _____
   _____

8. Do you have a history of any skin disease or sensitivity? *If YES Please explain:_____
   _____

9. Do you know your Skin Type? Fitz. Skin Type: I II III IV V VI

10. What is your daily intake of water (cups)? ☐ 0-2 ☐ 2-4 ☐4-6 ☐ 6-8 ☐ more

11. Do you engage in any light physical activity such as walking? Check which best applies:
    ☐ Never ☐ Rarely ☐ Sometimes ☐ Always

12. Do any of the discussed contraindications apply to you? ☐ YES* ☐ NO *If YES Please explain:_____
    _____

History:	**Yes**	**No**	**N/A**	**Date**
Recent Sun Exposure	X	X	X	_____
Previous Laser Treatments	X	X	X	_____
Hair Removal				
Waxing, Plucking, Electrolysis	X	X	X	_____
Accutane, last 6 months	X	X	X	_____
Gold Therapy	X	X	X	_____
Coagulopathies	X	X	X	_____
Herpes/Cold Sores	X	X	X	_____
Vitiligo	X	X	X	_____
History Melanoma	X	X	X	_____
Keloids/Hypertrophic Scarring	X	X	X	_____
Tattoos/Permanent Make-up	X	X	X	_____
Fillers, Botox etc.	X	X	X	_____
Pacemaker/Defibrillator	X	X	X	_____
Implants/Surgeries in treatment area	X	X	X	_____
Decreased sensation/Numbness in treatment area	X	X	X	_____

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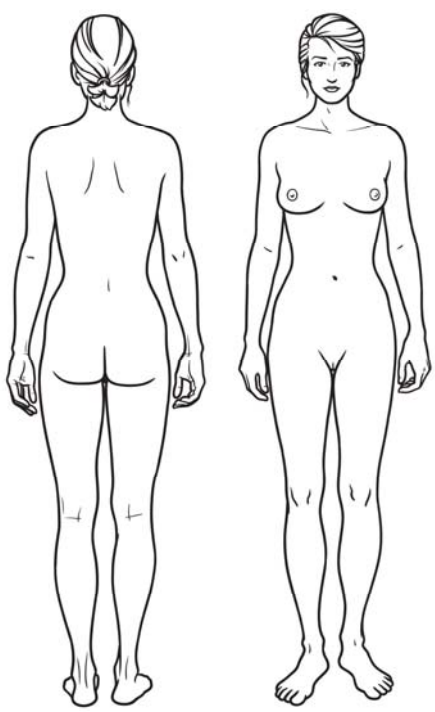
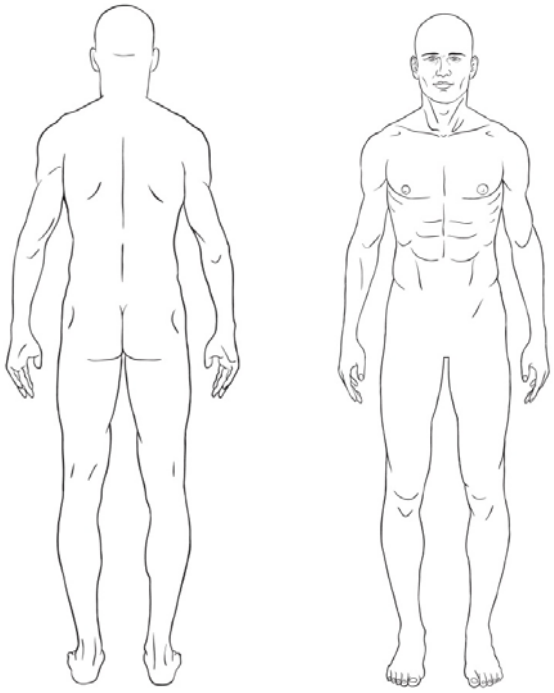
Occupational Health Services

13. Which area(s) are you interested in receiving Tru Sculpt treatments? Please list and mark the areas on the diagram.

Mark area(s) on diagram:

☐ N/A





☐ N/A

Patient signature below indicates that the above information is accurate and current.

Patient signature:_____

Date:_____

Clinician signature:_____

Date:_____

Clinic Treatment Notes

Baseline Measurements: Date_____ Weight:_____Lbs
Circumference:_____CM

Initial:

_____ Benefits of procedure discussed

_____ Contraindications reviewed

_____ Risks reviewed

_____ Probability of success reviewed

_____ Alternative procedures available

_____ Consent signed

_____ Verbal and written post-treatment instructions given to patient

_____ Pre-op photos taken

Appointment scheduled: Date: ____/____/____

Comments:

Signature of Consultant: _____

Post Tx Measurements: Date_____ Weight:_____Lbs
Circumference:_____CM

Post Tx Measurements: Date_____ Weight:_____Lbs
Circumference:_____CM

Post Tx Measurements: Date_____ Weight:_____Lbs
Circumference:_____CM

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Tru Sculpt Informed and Consent

Area(s) to be treated:_____

1. I hereby authorize Pear Tree Medical Clinic to treat me using the Tru Sculpt system.
2. I understand the results may vary from person to person and that an exact result cannot be predicted.
3. I understand that completing a full treatment series, administered 7-14 days apart, is necessary to maximize treatment efficacy.
4. I understand that good dietary habits, sufficient intake of water and light physical activity are beneficial and may optimize results.
5. I understand there are certain risks associated with Tru Sculpt treatments and they include but are not limited to
   - ~ Redness
   - ~ Edema of the skin, subcutaneous fat, and muscle tissue due to excessive heating
   - ~ Tissue tenderness
   - ~ Bruising

   Although unlikely, adverse effects such as skin burns and blisters may occur due to excessive heating.
6. I understand that the treatment may involve risks of complications or injury from both known and unknown causes, and I freely assume these risks.
7. I confirm that I do not have an inserted pacemaker, internal defibrillator, or metal implants. I am not pregnant or breastfeeding.
8. I have been advised to increase my water intake at least 24 hours before and after treatment. On the day of treatment, I will need to wear comfortable clothing and may have to remove all jewelry. The treatment area(s) will be exposed to various degrees of heat from the Tru Sculpt system. I may experience intense heat.
9. I agree to before and after treatment photographs, measurements, and weight as this will help in the evaluation of the results of the treatment.
10. I certify that I have read this entire document and that I agree with all provisions. I certify that I have had the opportunity to ask questions and these questions have been answered in full to my satisfaction. I fully understand the treatment conditions, the procedure and possible side effects.

I hereby give my consent and authorization and release Pear Tree Medical Clinic and it's Staff, of any claims that I have in the future connection with the described treatment.

SIGNATURE:_____DATE:_____

WITNESS:_____DATE:_____

Recommended Pre & Post Care for truSculpt Treatments

For best results please follow these instructions

Before your treatment:

- Excess hair may need to be shaved
- Notify clinic with any changes to your health history or medications since your last appointment

After your treatment:

- Tenderness, redness and swelling may occur and resolve within 24 hours
- Multiple treatments may be required
- Notify clinic if any of the following occur:
    - Blister, crusting or skin burns
    - Tenderness, redness or swelling persisting longer than 24 hours
    - Nodules or lumps in the treatment area
- May develop up to 72 hours post-treatment

- Additional instructions: _____

_____

If you have any questions, please contact us at: (586) 991-0903.