Cryoskin 3.0: Information Form

First Name:_____ Last Name: _____

Background Information

1. Have you had any other aesthetic procedure(s) before? Yes No

2. If "yes", what? _____

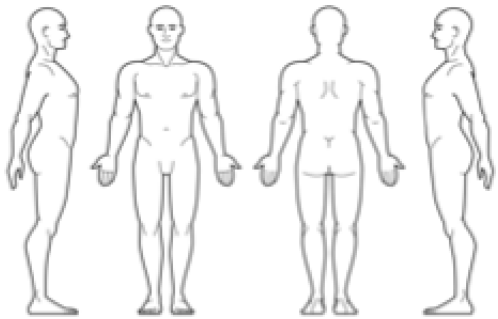
3. How did you hear about Cryoskin 3.0? TV Friend Internet Podcast Other:_____

Cryoskin 3.0 Information

1. Do you have any of the following? (*Check all that apply*)

☐ Botox/Fillers (last 3 months)	☐ Surgery (last 3 months)	☐ Breast Implants
☐ Pregnant	☐ Lactation	☐ Cancer (present or past)
☐ Cold Sensitivity/Reynaud's	☐ In Vitro Fertilization (IVF)	☐ Open or Infected Wounds
☐ Scar Tissue (in the area to be treated)	☐ Eczema, Rashes or Dermatitis	☐ Circulation Disorder(s)
☐ Liver and/or Kidney Disease	☐ Diabetes	☐ Foreign Ointments on Skin

2. Please circle area of focus for today's Cryoskin 3.0 treatment:



3. What other treatments/medications/exercises or diets have you tried (*for the items you checked above*)?

_____

4. Did any of the other treatments/medications/exercises work? 1Yes 1No

5. What is your goal with Cryoskin 3.0? _____

5. Do you have any specific questions about Cryoskin 3.0?

_____

Pictures will be obtained for records. If pictures are used for education and marketing purposes, all identifying marks will be cropped or removed, unless the Cryoskin 3.0 treatment is done on the face.

Initial: _____