AlmaTED

HAIR LOSS MASTERS

Medical History

Name: ____________________

Address: ____________________

Home Phone: ____________ Work: ____________ Cell: ____________

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, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
- ☐ Use of photosensitive medication and/or herbs that may cause sensitivity to 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? ☐ Yes ☐ No
- ☐ 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? ☐ Yes ☐ No

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 a tanning booth)? ____________

Do you use chemical sun tanning lotions? ________ Are you planning a holiday in the sun? ________

Reason for visit (area to be treated)? ____________________

Prior treatment (if any)? ____________________

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HAIR LOSS MASTERS

Hair Loss History Form

Name: ______________________________ DOB: ______________

How did you hear about us? ______________________________

Where is your hair loss?

- ☐ Scalp
- ☐ Eyebrows
- ☐ Eyelashes
- ☐ Other

How did the hair loss occur?

- ☐ Gradual (slow, advancing step by step)
- ☐ Sudden (happened quickly, w/no warning)

How severe is your hair loss?

- ☐ Mild (25% or less of hair lost)
- ☐ Moderate (25-50% of hair lost)
- ☐ Severe (75% or more of hair lost)

How long have you had hair loss (Please specify in numbers)?

☐ Years: __________ ☐ Months: __________ ☐ Weeks: __________

Does your scalp have any of the following symptoms?

- ☐ No symptoms
- ☐ Bumps
- ☐ Burning
- ☐ Flaking
- ☐ Drainage
- ☐ Itching
- ☐ Redness
- ☐ Scaling
- ☐ Tenderness
- ☐ Other: ______________________________

Please check all that apply:

- ☐ A recent hospitalization
- ☐ A recent surgery
- ☐ A systemic disease
- ☐ Unintentional weight change
- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ A recent illness
- ☐ Anemia
- ☐ NONE of the above

Have you had any previous bloodwork/labs done (Ferritin, TSH, etc)

- ☐ Yes If so, when? ______________________________
- ☐ No

What are you currently taking or using to treat hair loss?

- ☐ Biotin
- ☐ Clobetasol
- ☐ Minoxidil 2% (Rogaine)
- ☐ Minoxidil 5% (Rogaine)
- ☐ Propecia/Finasteride
- ☐ Other: ______________________________
- ☐ None/No treatment

Who in your family has or had hair loss/thinning/balding?

- ☐ Brother
- ☐ Sister
- ☐ Daughter
- ☐ Son
- ☐ Father
- ☐ Mother
- ☐ Cousin
- ☐ Aunt
- ☐ Uncle
- ☐ Grandfather – Paternal
- ☐ Grandfather - Maternal
- ☐ Grandmother – Paternal
- ☐ Grandmother - Maternal

Additional History:

____

____

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TED Treatment Form

Patient: ______________________________ Date: ______________

Physician: ______________________________ Operator: ______________________

Medical History Completed: ☐ Yes ☐ No Consent Signed: ☐ Yes ☐ No

Photos Taken: ☐ Yes ☐ No

Procedure: ____

Area Treated: Scalp ☐ Face ☐ Other: ______________________________________

Topical Administered: ____

Date	Number of treatment zones	Prime Treatment Zones Hz / Intensity % / Minutes	Topical Delivery Hz / Intensity % / Minutes

Notes

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Alma TED

HAIR LOSS MASTERS

Disclosure and Consent to Procedure for
ALMA TED

1. Reason for Procedure: I am seeking treatment for the following condition:

   Hair Restoration

2. The Procedure. I have requested that the undersigned physician at the Clinic perform the following procedure (the "Procedure"):

   Seeking improvement in hair growth.

3. Risks. There are risks related to the performance of this Procedure. I understand and acknowledge that the risks associated with this particular Procedure may include the following:
   [*This list of possible risks must be reviewed and edited by a qualified physician involved in the care of the patient. Some of the risks listed below may not apply to the specific Procedure, and there may be additional risks associated with the Procedure that should be added*]

   a. Discomfort and pain – I acknowledge that I will experience some discomfort during and after the Procedure. Long term pain after completion of the procedure is a possible but rare side effect.

   b. Infection – Although rare, infection is a possibility any time a Procedure is performed. It is possible, but rare, for an infection to spread in the body. If an infection spreads, that could require hospitalization. [*If applicable,* add *description of effects of this possibility*]

   c. Blood clots in veins and lungs –The Procedure could cause blood clots. Blood clots that travel to the heart or lungs could cause to an emergency medical condition. [If applicable, a*dd description of effects of this possibility*]

   d. Allergic reactions –I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me. I have discussed all known allergies with my treating physician.

   e. Bruising – Bruising in the treated area is possible, especially if, within the last ten (10) days, I have taken aspirin or aspirin-containing products, or other medications that "thin" the blood. I will discuss any medications I am taking with my doctor.

   f. Blindness and eye damage – If I am not wearing protective eyewear, the laser used in the Procedure could visual loss, including blindness. I understand that I will be provided with protective eye shields. I acknowledge that it is important to keep these shields on at all times during the Procedure and that I should also keep my eyes closed in order to protect my eyes from accidental laser exposure.

   g. Painful or unattractive scarring – Scarring is a rare complication of laser assisted treatment, but scarring is possible. To minimize the chances of scarring, it is most important that I follow all instructions carefully after my procedure.

   h. Pigment changes (skin color) – During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.

   i. Poor healing – An open wound may require more than the usual one to three weeks to heal. This could require further treatment.

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4. Other Medical Conditions. My doctor and the Clinic staff need information about my health history in order to perform the Procedure. Please initial where indicated below:[*To be reviewed and edited by a qualified physician; some of the below suggested contraindications may not apply to the specific Procedure and additional contraindications might apply*]:

   a. Pregnancy. The Procedure is not suitable if you are pregnant. I am not pregnant and have had a pregnancy test within the past 24 hours. ____

   b. Age. The Procedure should not be performed on pages in certain age groups. I am between the ages of 25 and 65. ____

   c. Pap smear and pelvic Exam. I have had a Pap smear and a pelvic exam within the past 30 days, the results of which have been provided to the Clinic. ____

   d. Oral antiviral medicine. If applicable [*explain when applicable*] I have taken prophylactic oral antiviral agents for the prevention of Herpes Simplex Virus. ____

   e. Other. I have had other health warnings explained to me by the Clinic and I agree that none of those warnings apply to me. I agree to comply with all precautions recommended by my Doctor.

5. No Guarantee of Success. I acknowledge that no guarantees have been made to me as to the results that will be achieved. It is possible that multiple Procedures may be required and that even then success might not be achieved.

6. Consent to Photography. For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from the Clinic, I hereby consent to have the Clinic's staff take before, during, and after treatment close-up photographs of the involved area (s) and the anatomical region surrounding the involved area (s). These photographs shall be used for medical records only and shall be treated with the same confidentiality as the remainder of my record at the Clinic.

I have been given an opportunity to ask questions about my condition, alternate forms of anesthesia [*if applicable*] and treatment, the procedure to be used, and the risks and hazards involved. My doctor has answered all of my questions.

I believe that I have sufficient information to consent to treatment. By signing below, I certify that I have read and understand this document.

I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment.

I voluntarily consent and authorize that this Procedure to be performed by *Dawn Bacchi.*

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Signature of Patient
(Parent or Guardian, if applicable)

Signature of Physician

Print Name of Patient

Print Name of Physician

Date

Date

Witness

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