A&WMC
PRP Hair Treatment

Name:_____ Date:_____
(First) (Last)

Date of Birth:_____ Age:_____ Weight:_____ Height:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Occupation: _____

Email Address:_____

Where is your hair loss?

☐ Scalp ☐ Eyebrows
☐ Eyelashes ☐ Other

How did the hair loss occur?

☐ Gradual
☐ Sudden

How severe is your hair loss?

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

How long have you had hair loss?

☐ Years:_____ ☐ Months:_____ ☐ Weeks:_____

Does your scalp have any of the following symptoms?

☐ Tenderness ☐ Itching ☐ Burning ☐ Flaking
☐ Bumps ☐ Patch ☐ Redness ☐ Other:_____

Please check all that apply:

☐ A recent hospitalization ☐ A recent surgery ☐ A systemic disease
☐ Unintentional weight change ☐ Hypothyroid ☐ Hyperthyroid
☐ A recent illness ☐ Anemia ☐ Covid infection

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

☐ Nutrafol ☐ Spironolactone ☐ Minoxidil (Rogaine) ☐ Minoxidil tablets
☐ Propecia/Finasteride ☐ Other:_____ ☐ No treatment

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

☐ Brother ☐ Sister ☐ Daughter ☐ Grandfather ☐ Uncle
☐ Father ☐ Mother ☐ Son ☐ Grandmother ☐ Aunt

Additional History: _____

_____

A&WMC
PRP Hair Treatment

CONSENT FOR PRP HAIR PROCEDURE

I give my informed and voluntary consent and authorize Dr. Angelica Hernandez and the staff of Adolescent & Women Medical Care to perform the PRP hair procedure. I understand that this treatment involves the injection of platelet-rich plasma (PRP) into the scalp.

I certify that I have been fully informed of the nature, purpose, expected benefits, and possible complications of this procedure. I understand that no specific outcome can be guaranteed, as outcomes may vary depending on individual response.

I confirm that I have disclosed all current and past medical conditions, illnesses, and medications to the medical team.

I agree to have before and after photographs taken, and consent to the application of anesthetics as well as the potential use of Pro-Nox (laughing gas) as part of this procedure.

I understand that smoking may reduce the effectiveness of this treatment due to the negative impact of toxins on the stem cells response.

I fully agree to release and hold harmless Adolescent & Women Medical Care, Dr. Angelica Hernandez and all affiliated parties, from any liability that may arise as a result of this treatment now and in the future.
I certify that I have been given the opportunity to ask questions and that I have read and fully understand the content of this consent form.

Patient Name:_____

Signature:_____

Date:_____