A&WMC
TED 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
TED Treatment

TED CONSENT FOR PROCEDURE

I give my informed and voluntary consent and I authorized Dr. Angelica Hernandez and staff of Adolescent & Women Medical Care to administer the TED (TransEpidermal Delivery) treatment for hair loss. TED, is a non-invasive, painless hair restoration procedure that delivers specific peptides into the scalp using ultrasound technology.

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 staff.

I agree to have before and after photographs taken.

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:_____

A&WMC
TED Treatment

PRE-TREATMENT INSTRUCTIONS

- A physical evaluation and blood work may be required prior to treatment
- Arrive with clean and dry hair
- Do not apply any hair care products to the hair or scalp
- Remove hearing aids and any jewelry near to treatment area
- Photographs will be taken before treatment for documentation purposes.

DAY OF THE TREATMENT

- You may experience a mild heating sensation during the procedure; this is mild and should resolve within a few minutes.
- A brief, unpleasant sound may be heard during treatment due to the ultrasound device.

POST-TREATMENT INSTRUCTIONS

- Do not wash the treated area for at least 24 hours
- Avoid coloring your hair for one week following the treatment.

CONTRAINDICATIONS

- Pacemaker or brain stimulation device
- A Cochlear implant
- Allergy to the red tattoo dye or algae-based products.