SALEM COSMETIC CLINIC
For all your cosmetic needs

Hair Restoration case sheet

REVITALIZE REVIVE RESTORE

Consultation Form—Confidential Patient Information

First Name: _____ Last Name: _____ M.I.: _____

D.O.B: ____ / ____ / _____ Age: _____ Today's Date: ____ / ____ / _____

Month Day Year Month Day Year

Gender: _____ Ethnicity: _____ Preferred Language: _____

Marital Status: Married ☐ Single ☐ Divorced ☐ Separated ☐ Other: _____

Home Address: _____

City: _____ State: _____ Zip Cord: _____

Primary Phone: (____) _____ - _____ Secondary Phone: (____) _____ - _____

Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact Information

First Name: _____ Last Name: _____

Relationship to You: _____ Phone: (____) _____ - _____

How did you discover us? (Please, circle all that apply)

Google ISHRS Hair Transplant Network IAHRS Digital Ad TV Radio

Referral: Dr.: _____ Relative/Friend: _____

Last Name First / Last Name

Your Hair Loss History

My hair loss began at age: ____ My condition is: Rapidly worsening ☐ Worsening ☐ Slowing Down ☐ Stable ☐

Hair loss medications / treatments that I am currently using or have used are: Not Applicable ☐

	Now	Prior		Now	Prior		Now	Prior
Propecia	☐	☐	Regaine (Minoxidil)	☐	☐	Laser Therapies	☐	☐
PRP Injections	☐	☐	Supplements	☐	☐	Other	☐	☐

If supplements and / or "other," please list: _____

Office use only: _____

Your Hair Restoration History

I had the following hair restoration procedures: Not Applicable ☐

Date: _____ Type: _____ no. of grafts _____ MD _____

Date: _____ Type: _____ no. of grafts _____ MD _____

Date: _____ Type: _____ no. of grafts _____ MD _____

(Office use only: _____

_____ CONSULTATION RECORD)

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FAMILY HISTORY OF HAIR LOSS

Men: Father: _____ Grandfather/F: _____ Grandfather/M: _____ Uncle/F: _____ Uncle/M: _____ Brothers: _____

Women: Mother: _____ Grandmother/M: _____ Grandmother/F: _____ Aunts/M: _____ Aunts/F: _____ Sisters: _____

MEDICAL HISTORY

Allergies? _____ Reactions? _____

Other Surgeries? _____ General Anesthesia? _____

Chemotherapy treatments? _____ High fever? _____ Crash Diets? _____

Smoke? _____ Alcoholic drinks (weekly avg.)? _____ Recreational drug use? _____

Nutritional supplements/vitamins: _____ List all current medications: _____

CHRONIC CONDITIONS

Heart: _____ Diabetes: _____ Kidney: _____ Skin Infect: _____ Keloids: _____

Fainting: _____ Epilepsy: _____ Immune Deficiency: _____ HiBP: _____

Bleeding Problems: _____ Hepatitis: _____ Psoriasis: _____ Seborrhea: _____

Cancer: _____ Hair Pulling: _____ Nervousness: _____ Depression: _____

Other: _____

PHYSICAL EXAMINATION

Percentage of thinning: _____ FRONT: _____ TOP: _____ VERTEX: _____

Width of thinning (cm): _____ FRONT: _____ TOP: _____ VERTEX: _____

Percentage of miniaturization: _____ FRONT: _____ TOP: _____ VERTEX: _____

Prior Donor Depletion: _____

Densitometry: Occip. _____ Temp. _____ If applicable, Hair Pull _____ hairs (normal 3/5)

Color of Hair: _____ Color of Skin: 1 2 3 4 5 6 7 8 9 10

Scars (Describe, If any): _____ Condition of Scalp: Normal _____ Scaled _____ Scalp Elasticity 1 2 3 4 5

Density of hair: Sparse _____ Ave. _____ Dense _____ Texture of hair: Fine _____ Med _____ Coarse _____ Curliness of hair: Yes _____ No _____

Amount of posterior sideburn hair (cms): _____ Prior donor depletion: None _____ Moderate _____ Extensive _____

Donor availability – BACK: Poor _____ Fair _____ Good _____ Exc _____ SIDES: Poor _____ Fair _____ Good _____ Exc _____

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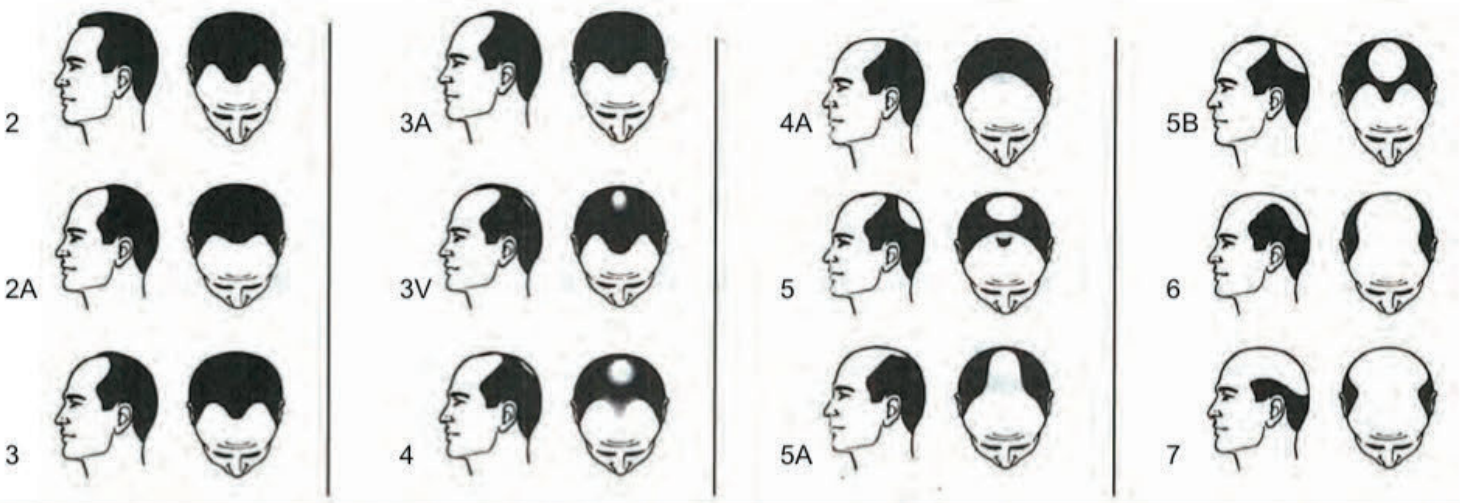
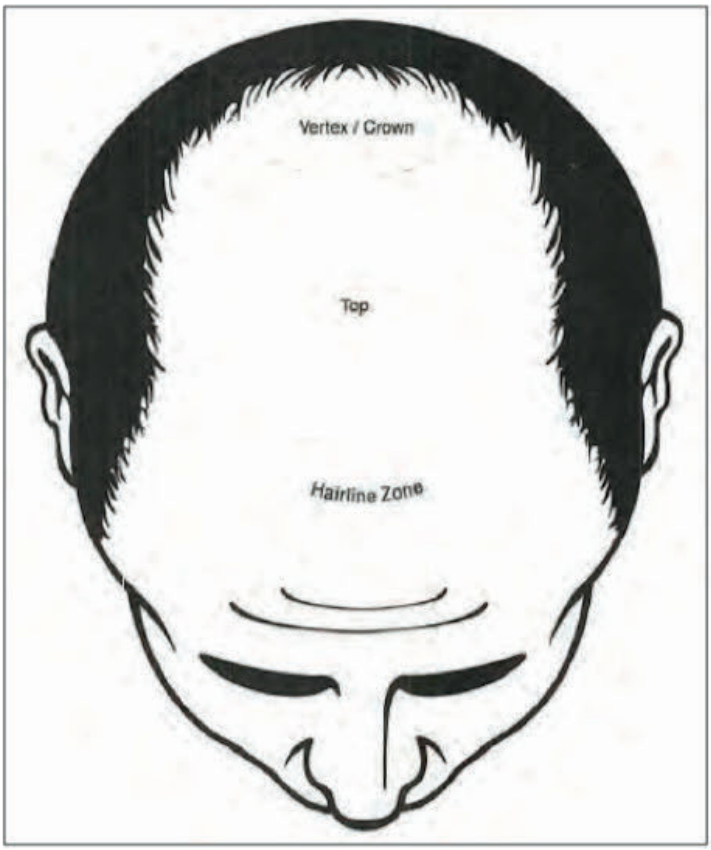
HAIR LOSS CLASSIFICATION



Female Ludwig Pattern's I, II, and III



DIAGNOSIS

Androgenetic Alopecia (Male Pattern Baldness).
Class _____

Female Genetic Alopecia Class _____

Other _____

Probable future progression to: Class _____

HAIRLINE – Length _____

Overall area: R_1 = _____ R_2 = _____

Estimated lifetime donor supply _____ grafts

Current target area(s) _____/_____/_____

Required FUs/cm² _____/_____/_____

Notes: _____

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- You are a good candidate for these procedures
- You are not suitable candidate for these procedures
- Previous hair restoration procedures by other physicians have resulted in problems which may impede your final results
- Your donor hair is limited relative to the size of the balding area

BEST OPTION

ALTERNATIVES

LONG TERM TREATMENT
☐ Finasteride (Propecia) ☐ Minoxidil (Rogaine)

Special Recommendations

SCHEDULING PROCESS—To book your procedure appointment, a 20% deposit is required. This deposit is non-refundable. The remaining balance will due the day of your procedure. Fees can be paid with most major credit cards. Financing options are available.

Physician's Signature

Date