A&WMC
TED Treatment

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

Date of Birth:_____ Age:_____ Weight:_____ Occupation:_____

Home Address:_____

City:_____ State:_____ Zip:_____

Cell Phone:_____ Alternative Phone:_____

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: _____

_____

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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 treatment for hair loss with TED, TransEpidermal Delivery.

I understand that clinical results may vary depending on individual factors. TransEpidermal Delivery, TED, is a non-invasive painless hair restoration treatment that delivers specific substances with the use of ultrasound. It is recommended for a minimum of 3 treatments at 4 weeks intervals.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

I consent to taking before and after photographs.

I fully agree to hold Adolescent & Women Medical Care, Dr. Angelica Hernandez and any and all parties affiliated with her, harmless and free from any liability that may arise as a result of this treatment both 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:_____

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Treatment Directions

Pre Treatment

- Physical evaluation
- Blood work
- Patient must arrive with clean hair, no hair care products applied to hair or scalp
- Remove hearing aids and/or jewelry near to treatment area
- Remove all makeup, moisturizers, or oils from the treatment area
- Take pictures before the treatment

Treatment

- You may feel heating sensation, it's mild and will resolve within few minutes
- Unpleasant sound may be heard during treatment

Post Treatment

- Do not wash the area for 24 hours
- Do not color your hair the following day

Contraindications

- Pacemaker or brain stimulation device
- Cochlear implant
- Allergy to the red dye tattoos or algae