TeleMedicine Consultation: Instructions

For a virtual consultation, tear out the following three light green pages, fill out and mail or fax to Dr. Elliott.

You will need to submit a series of photos of your head (samples below; phone pics okay): front, back, both sides, and top. These can be emailed as attachments or texted to the office iPhone.

Please be sure to hold a card with your name on it so that it is visible in at least one of the photos.

MAIL: 11645 Wilshire Blvd Suite 1100 Los Angeles CA 90025
FAX: 310-914-4009
EMAIL: PacificHairClinicLA@gmail.com
TEXT: 949-423-5950 (phone pics)
LAURA: 949-378-1400 (if you need assistance)

Privacy Notice. Your photos are never posted where the public can see them. All photos submitted to us are held in strict confidence as part of your medical record. Any patient whose photos appear on the website have given us their permission and signed a model’s release.
TeleMedicine Consultation: Tear-out

Originating office: ______________________ How did you hear about us? ______________________

BIOGRAPHICAL DATA

Name: ______________________ Date: ______________________

Birthdate: ______________________ Age today: ______ Marital Status: ______

Address: ____________________________________________________________________________

City: ______________________ State: ___________ Zip: ___________

Cell Phone: ______________________ E-Mail Address: ______________________

Occupation: ______________________

HISTORY OF HAIR LOSS AND PRIOR TREATMENTS

Hair loss began at age: ______________________

Current hair loss: □ is continuing □ has slowed down □ has stabilized

if stabilized, for how long? ______________________

Any prior procedures (transplant, scalp reduction, etc.) for hair loss?

Date: ___________ Type: ___________ MD: ___________ City: ___________

Date: ___________ Type: ___________ MD: ___________ City: ___________

Date: ___________ Type: ___________ MD: ___________ City: ___________

Date: ___________ Type: ___________ MD: ___________ City: ___________

List any other previous treatments and / or medications for hair loss:

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Using a hairpiece? □ No □ Previously □ Currently

List all current medications for hair loss:

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________
1) Are you very concerned about the appearance of your hair loss or other parts of your body which you consider especially unattractive? ........... □ YES □ NO
   • IF YES: Do these concerns preoccupy you? (That is, you think about them a lot and wish you could worry about them less.) ........... □ YES □ NO
   • IF YES: What specifically bothers you about the appearance of your hair loss or other parts of your body? Please explain in detail:

   ______________________________
   ______________________________
   ______________________________

   NOTE: If you answered “NO” to either of the above questions, go to the Family History section on next page. Otherwise continue below.

2) What effect have your feelings about your hair loss or other part of your body had on your life?
   Have your feelings about your hair loss or other part of your body often caused you a lot of distress, torment or pain? ..................... □ YES □ NO
   Have your feelings about your hair loss or other part of your body significantly interfered with your social life? ..................... □ YES □ NO
   Have your feelings about your hair loss or other part of your body significantly interfered with your school work, your job, or your ability to function in any other responsibility in your life? ..................... □ YES □ NO
   • IF YES: How?
     ______________________________
     ______________________________
     ______________________________

   Are there things that you avoid because of your hair loss? ..................... □ YES □ NO
   • IF YES: What are they?
     ______________________________
     ______________________________
     ______________________________

3) How much time do you spend thinking about your hair loss or other part of your body per day on average?
   □ Less than 1 hour a day  □ 1-3 hours a day  □ More than 3 hours a day
   Have the lives or normal routines of your family or friends been affected by your hair loss or other part of your body? ..................... □ YES □ NO
   • IF YES: Explain ______________________________________________________
     ______________________________
     ______________________________
     ______________________________

   □ TELEMEDICINE CONSULTATION: Tear out and fax (310) 914-4009 or mail to: 11645 Wilshire Blvd Ste 1100 Los Angeles CA 90025
TELEMEDICINE CONSULTATION: Tear-out

FAMILY HISTORY OF HAIR LOSS
(Put number in each blank below of closest hair loss classification on next page)

Father: ___________________  Grandfather/ F: ___________________  Grandfather/ M: ___________________
Uncles/ F: ___________________  Uncles/ M: ___________________  Brothers: ___________________

MEDICAL HISTORY

Allergies: ___________________________________________  Reactions: ___________________________________________
Other surgeries: ______________________________________  General Anesthesia: ________________________________
Chemotherapy treatments? _____________________________  High fevers? _________________________________
Crash Diets? ________________________________________  How often do you smoke? ___________________
Alcoholic drinks (weekly avg.): ________________________  Nutritional supplements/vitamins: ____________________

List all current medications:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

My diet is:  □ Good  □ Fair  □ Poor

CHRONIC CONDITIONS

Heart: ___________________  Diabetes: ___________________  Skin Infect: ___________________
Keloids: ___________________  Fainting: ___________________  Epilepsy: ___________________
Immune Deficiency: ___________________  High BP: ___________________  Bleeding Problems: ______
Hepatitis: ___________________  Psoriasis: ___________________  Seborrhea: __________________
Cancer: ___________________  Blood type if known: ______  Nervousness: __________________
Depression: ___________________  Skin Spots: ___________________  Skin Cancer: ____________

PHYSICAL MAKEUP

Ancestry (i.e. Polish, Italian, etc.): ___________________
Color of hair as a teenager: ___________________

Color of skin:  □ Fair  □ Medium  □ Dark