900 SE Oak Street, Suite 203
Hillsboro, OR 97123
PHONE 503.693.1118 FAX 503.640.6461

HIPAA COMMUNICATION FORM

Patient name :______________________________________Date of birth: ___________________

I give permission for Dr. Gabel and/or his staff to send mail to the following address:

Address : ____

City:___________________________State: ___________________ Zip Code:_______________

I give permission for Dr. Gabel and /or his staff to call me at the number(s) checked below :

- ☐ Home phone : __________________________________
- ☐ Work phone : __________________________________
- ☐ Cell phone : __________________________________
- ☐ E-mail address : ________________________________

Who may we speak with at your telephone number(s)? Please check all that apply:

- ☐ May speak to anyone who answers the phone.
- ☐ May speak only with spouse : Name : _______________________________________
- ☐ May speak with : _______________________________ Relation : _______________
- ☐ May not speak with anyone except myself .

Leaving a message on the phone, please check all that apply :

- ☐ May leave any message.
- ☐ May identify yourself and leave a number to return call.
- ☐ Do not leave any message on my answering machine.

_____________________________________ _______________________________

Patient Signature Date

Please complete this questionnaire in black ink. The following information is important to your health. Please take the time to accurately and completely fill this out.

PATIENT HISTORY

Name: ______________________________________ **Date of Birth**: ___________________

Gender: **M** **F** **Age**: ____________

Hair Loss History: Age of onset of hair loss: ________

Above average hair loss recently: ☐ Yes ☐ No

What are your current hair loss concerns?

- ☐ Starting to thin
- ☐ Advanced stage of thinning
- ☐ Receding hairline
- ☐ Bald spot in the crown
- ☐ Little or no hair on top of scalp
- ☐ Thin eyebrows
- ☐ Sparse eyelashes
- ☐ Postoperative plastic surgery hair loss
- ☐ Increased shedding of hair

Other:____

Have you experienced the following conditions?

	In the past	Currently
Scalp tenderness or pain	☐	☐
Scalp itching	☐	☐

Have you used any of the following?

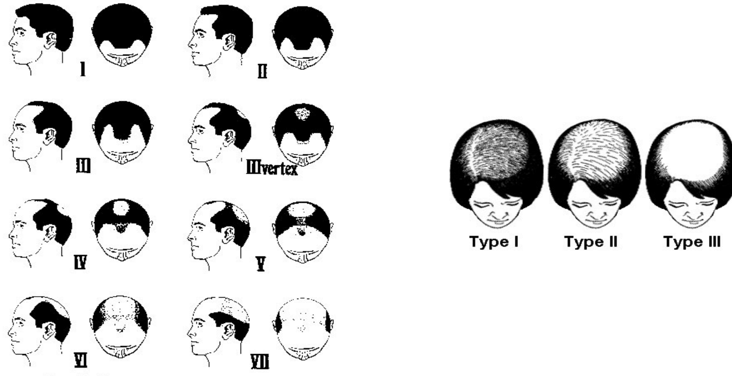
	In the past	Currently
Hair color	☐	☐
Hair perm	☐	☐
Hair piece	☐	☐
Minoxidil (Rogaine®) treatment	☐	☐
Finasteride (Propecia®) treatment	☐	☐
Shampoo for thinning hair	☐	☐
Vitamins/Minerals/Herbs	☐	☐

Which of your family members have/had hair loss?

☐ Mother	☐ Father	☐ Brother(s)
☐ Mother's Father	☐ Father's Father	☐ Sister(s)
☐ Mother's Mother	☐ Father's Mother	☐ Other(s)

Name:____ **Date of Birth**: ____________________

Please circle the diagram which you feel closely matches your hair loss pattern.



Which area(s) do you wish to restore:

☐ Hairline restoration
☐ Increase in frontal density
☐ Crown coverage
☐ Stop hair loss or decrease shedding
☐ Touch-up, refinement, or correction of previous procedure
☐ Scar coverage

Please state your goals and objectives:

____

____

____

Have you ever had any hair restoration procedures in the past? (If yes, please indicate date(s), area(s) transplanted, and number of grafts placed)

____

____

____

Please check all referrals that apply. (Who should we thank?)

☐ Internet ____

☐ Newspaper ____

☐ Television ____

☐ Friend/Patient ____

☐ Other ____

Name: ____ **Date of Birth**: _____________________

Past Medical History: Please check YES or NO for every condition listed below.

YES	NO		YES	NO	
□	□	History of Alopecia Areata	□	□	Lung Disease
□	□	Low Iron	□	□	Stroke/TIA
□	□	Lupus	□	□	Kidney Problems
□	□	Hair Pulling	□	□	Diabetes
□	□	Thyroid Disease	□	□	Cancer
□	□	Polycystic Ovarian Syndrome	□	□	Rheumatic Heart Disease
□	□	Keloid Formation	□	□	History of Rheumatic Fever
□	□	Scarring	□	□	Mental Illness
□	□	Bleeding Disorder	□	□	Depression/Anxiety
□	□	HIV/Hepatitis	□	□	Asthma
□	□	High Blood Pressure	□	□	Implants
□	□	Irregular Heart Beat	□	□	Prosthetic Joints
□	□	Coronary Heart Disease	□	□	Substance Abuse
□	□	Heart Murmur	□	□	Problems with local anesthesia

Do you have any medical conditions that are not listed above?

____

Are you presently under the care of a physician for any of the above conditions?

____

Please list ALL surgery you have had including the date(s).

____

____

Current Medications (please list all medications including over the counter medications; for example, aspirin or other blood thinners, vitamins, herbs, or supplements):

____

____

Allergies to medications:____

Social History: Current occupation: ____

Smoking:
- □ Never smoked
- □ Previous smoker (When did you quit?______________________)
- □ Currently smoke ______ packs/day for ______ years

Alcohol: □ Daily □ Occasionally □ Rare □ Never

□ **Skype Consult Disclaimer**: This online webcam Skype consultation is a service provided by Dr. Steven Gabel and the Gabel Center. I fully understand that the information provided by Dr. Gabel and/or his staff is general information for educational purposes only and does not constitute medical advice, and is not intended to provide a diagnosis, nor does it substitute for an actual in-person consultation with Dr. Gabel that is necessary prior to any plastic surgery procedure. Participants in this consultation agree not to hold any parties liable to the opinions given herein. These consultations may or may not be recorded for educational purposes, and are not available for any future reference or use. Please check the Skype Consult Disclaimer box if you agree to this disclaimer prior to your Skype Consult with Dr. Gabel.

The above information is true and correct to the best of my knowledge.

____ ____________________________

Signature of Patient **Date**