

毛髪再生同意書（PRP / 移植）

PRP頭皮注射、マイクロニードリング、毛包単位抽出手術を含む毛髪再生治療に対する事前説明同意書

クライアント情報

First Name *

Last Name *

Email Address *

Phone Number *

Date of Birth *

YYYY年MM月DD日

治療詳細

Treatment *

- | | |
|--|---|
| ☐ PRP scalp injections | ☐ PRP with microneedling |
| ☐ Follicular unit extraction (FUE) transplant | ☐ FUE eyebrow / beard transplant |
| ☐ Exosome or growth-factor therapy | ☐ Other |

Areas *

- | | | |
|-----------------------------------|---|---|
| ☐ Crown | ☐ Hairline / Temples | ☐ Diffuse thinning |
| ☐ Eyebrows | ☐ Beard | ☐ Scar coverage |

How long have you noticed hair loss? *

- | | | |
|---------------------------------------|------------------------------------|--|
| ☐ Under 1 year | ☐ 1-5 years | ☐ More than 5 years |
|---------------------------------------|------------------------------------|--|

Has a physician diagnosed the cause of your hair loss? *

- ☐ Yes ☐ No

Treatments tried so far (minoxidil, finasteride, supplements, prior PRP or transplant)

医歴

Are you pregnant, trying to conceive, or breastfeeding? *

- ☐ Yes ☐ No

Do you have any of the following?

- | | |
|--|---|
| ☐ Autoimmune condition (lupus, RA, MS, etc.) | ☐ Bleeding disorder or on blood thinners |
| ☐ Diabetes | ☐ History of keloid or hypertrophic scarring |
| ☐ Cancer (current or within the last 5 years) | ☐ Immunosuppressed / immune disorder |
| ☐ None of the above | |

Do you have an active scalp infection, psoriasis, folliculitis, or open wounds? *

- ☐ Yes ☐ No

Do you have alopecia areata, scarring alopecia, or an autoimmune hair condition? *

- ☐ Yes ☐ No

Do you have a platelet or blood disorder, or are you on anticoagulants? *

- ☐ Yes ☐ No

Have you taken isotretinoin (Accutane) in the last 6 months? *

- ☐ Yes ☐ No

Do you smoke or vape nicotine? *

- ☐ Yes ☐ No

Are you pregnant or breastfeeding? *

- ☐ Yes ☐ No

Current medications and supplements

Allergies (medications, latex, lidocaine, anesthetics)

リスクと合併症

Potential Risks and Complications:

- Scalp tenderness, swelling, and bruising for several days; forehead swelling after hairline treatment
- Bleeding at injection or extraction sites
- Infection or folliculitis
- Temporary shedding of existing hair (shock loss) 2–8 weeks after treatment, usually recovering
- Numbness or altered sensation of the scalp, usually temporary
- Small dot scars in the donor area after FUE; visible thinning of the donor area if over-harvested
- Poor graft survival, unnatural hairline, or uneven density requiring further sessions
- Cysts or ingrown hairs at graft sites
- No response — PRP results vary and require a series of 3–4 sessions plus maintenance; hair loss continues in untreated areas

Results take 3–6 months (PRP) or 9–12 months (transplant) to become visible.

I understand that hair restoration results are gradual, vary between individuals, may require a series of treatments and ongoing medical therapy, and that no specific density or coverage has been guaranteed.

I understand results vary and take months: _____

I understand the risks of bleeding, infection, shock loss, scarring, numbness, and poor graft survival, and that I have disclosed all medications, scalp conditions, and nicotine use.

I understand the surgical and injection risks: _____

写真使用許諾

May we take before-and-after photos for your treatment record? *

- ☐ Yes — for my medical record only
- ☐ Yes — and you may use them anonymously for marketing
- ☐ No

サービスログ

オフィス使用のみ

Service Log

	Date	Area	Treatment / Grafts / Volume	Notes
Entry 1				
Entry 2				
Entry 3				
Entry 4				
Entry 5				
Entry 6				

同意および署名

I voluntarily consent to the hair restoration treatment selected above. I have been informed of the benefits, risks, alternatives (including medical therapy and no treatment), and potential complications. I understand this is an elective procedure and no guarantee of outcome has been made. I release the provider and practice from liability related to this treatment except in cases of negligence.

I confirm I have read and understood the above information and give my informed consent.

I have read and understand the above information: _____

Signature

日付

名前を記入

Date *

YYYY年MM月DD日

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