CALIFORNIA HAIR AND SKIN INSTITUTE

INFORMED CONSENT FOR MINOXIDIL FOR HAIR LOSS TREATMENT

(TOPICAL AND ORAL)

Patient Name: _____
Date of Birth: _____
Medical Record Number: _____
Date: _____

Treating Physician: Vakas Sial, MD

PURPOSE OF THIS CONSENT

This document explains the benefits, risks, alternatives, and limitations of Minoxidil therapy for hair loss.

Please read this document carefully and ask any questions before signing.

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1. NATURE OF THE MEDICATION

I understand that Minoxidil may be prescribed in topical or oral form to support hair growth.

Minoxidil works by stimulating hair follicles and prolonging the growth phase of the hair cycle.

The form of treatment prescribed may include:

☐ Topical Minoxidil
☐ Oral Minoxidil

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2. EXPECTED BENEFITS

Potential benefits may include:

- Supporting hair growth
- Improving hair thickness
- Prolonging the active growth phase of hair follicles
- Reducing progression of hair thinning in some patients

I understand:

- Results vary among individuals.
- Several months of treatment may be required before improvement is noticed.
- Continued use may be necessary to maintain benefits.
- Results cannot be guaranteed.

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3. TOPICAL MINOXIDIL RISKS AND POSSIBLE SIDE EFFECTS

Possible side effects of topical Minoxidil include:

- Scalp irritation
- Dryness
- Itching
- Flaking
- Redness or irritation
- Unwanted facial hair growth
- Temporary initial shedding

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4. ORAL MINOXIDIL RISKS AND POSSIBLE SIDE EFFECTS

I understand that oral Minoxidil is used for hair loss treatment under physician supervision.

Possible side effects include:

- Increased heart rate
- Lower blood pressure
- Dizziness
- Lightheadedness
- Fluid retention
- Swelling
- Headache
- Excess body hair growth
- Rare cardiac complications

Patients taking oral Minoxidil require physician monitoring and should report concerning symptoms promptly.

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5. MEDICAL HISTORY DISCLOSURE

I certify that I have informed my physician of any relevant medical conditions, including:

☐ Heart disease
☐ Blood pressure conditions
☐ Kidney disease
☐ Current medications
☐ Allergies
☐ Supplements
☐ Previous medication reactions

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6. ALTERNATIVES

Alternative treatments may include:

- No treatment
- Hair transplantation
- PRP therapy
- Finasteride
- Dutasteride
- Low-level laser therapy
- Hair camouflage products
- Observation

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7. NO GUARANTEE OF RESULTS

I understand:

- Medicine is not an exact science.
- Hair growth response varies among individuals.
- No guarantees or warranties have been made regarding my results.
- Additional treatments may be recommended.

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8. FOLLOW-UP CARE

I agree to:

- Take Minoxidil only as prescribed.
- Follow physician instructions.
- Attend recommended follow-up appointments.
- Notify the office of unexpected symptoms or concerns.

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9. QUESTIONS AND CONSENT

I certify that:

- I have had sufficient opportunity to ask questions.
- My questions have been answered to my satisfaction.
- I understand the benefits, risks, alternatives, and limitations of Minoxidil therapy.
- I voluntarily consent to treatment.

PATIENT CONSENT

I authorize Dr. Vakas Sial and the California Hair and Skin Institute clinical team to prescribe and manage Minoxidil therapy when medically appropriate.

Patient Signature: _____

Printed Name: _____

Date: _____

PHYSICIAN CERTIFICATION

I certify that I have discussed the nature of the proposed medication, anticipated benefits, material risks, alternatives, and answered the patient's questions.

Physician: Vakas Sial, MD

Signature: _____

Date: _____