The Lam Institute for Hair Restoration
Samuel. M. Lam, M.D.

Patient Encounter Form

Name: Last _____ First: _____ M.I._____ Date__/__/__

Street Address: _____ Apt #_____

City: _____ State: _____Zip: _____ D.O.B. __/__/__

Sex __M __F SS # _____-___-_____ Email: _____

Phone _____(h) _____ (w) _____ (cell)

Occupation _____ Age _____ Preferred way of contact_____

How did you hear about us?_____

Emergency Contact _____Phone#_____

Primary Care Physician's phone #_____

Pharmacy phone#_____fax#_____

What is your primary interest(s) in coming here? (Check all that apply)
□ Slow hair loss □ Maintain hair count □ Restore hair □ Other _____

How long have you been concerned about your hair loss?
□ Less than 1 year □ 1-5 years □ 5 years and more

What type of hair loss solution(s) have you tried? (Check all that apply)
□ Propecia □ Rogaine □ Hair transplant □ Hairpiece □ Laser

What surgeries have you had in the past and when (including hair transplant)?
_____

What other medical problems do you have? _____

Are you taking any medication? (Please list) _____

Do you have any medication allergies? _____

Explain your allergic reaction: _____

Federal Law requires us to obtain a valid Driver's License or current Photo ID for your records. Please provide a copy with your consultation form.