

HAIR RESTORATION PATIENT HEALTH HISTORY

<u>Date</u> _____		<u>Referred By</u> _____	
<u>Patient Name</u> _____			
<u>Address</u> _____			
<u>City</u> _____	<u>State</u> _____	<u>Zip</u> _____	
<u>Phone (home)</u> _____	<u>Phone (work)</u> _____	<u>E-mail</u> _____	
<u>Date of Birth</u> _____	<u>Age</u> _____	<u>Occupation</u> _____	
<u>Marital Status (circle one)</u> <u>Single / Married / Separated / Divorced / Widow</u>			
<u>Emergency Contact</u> _____	<u>Phone</u> _____	<u>Relationship</u> _____	
Do you have any allergies or sensitivities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list. _____	
Are you currently taking any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list. _____	

Are you currently taking any aspirin, ibuprofen, minerals, herbs, or nutritional supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please list. _____			
<u>Family Physician</u> _____	<u>Phone</u> _____	<u>City / State</u> _____	
Do we have permission to obtain additional health information from your family physician? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you had any other type of surgery before?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify the type.	
Type of surgery _____	Date _____		
Type of surgery _____	Date _____		
Type of surgery _____	Date _____		
Where there any type of complications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify.	

Have you ever received local anesthesia (Novocain, Xylocaine, etc) by a dentist or doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you ever had a reaction to anesthesia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe the type of reaction.	

When was your last physical examination? _____			
Do you have a history of bleeding?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please specify.	

<input type="checkbox"/> Bleeding from the nose	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Vomiting blood	
<input type="checkbox"/> Bleeding from the rectum	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Other _____	
Please explain and list any other bleeding problems. _____			

- Are you frequently sick or ill? Yes No
- Have you ever taken hormone or thyroid medications? Yes No
- Are you double jointed? Yes No
- Can you touch your tongue to your nose or your thumb to your forearm? Yes No
- Do you smoke cigarettes? Yes No
- Do you drink more than 6 cups of coffee per day? Yes No
- Do you normally have more than 2 drinks of alcohol per day? Yes No
- Have you ever been under the care of a psychologist or psychiatrist? Yes No
- If yes, please explain. _____

- Do you understand that medical and surgical treatments cannot promise or guarantee a good outcome? Yes No
- Do you understand that all risks and complications cannot be prevented when a surgical procedure is performed? Yes No

WOMEN

- Is there a history of breast cancer in your family? Yes No If yes, please specify. _____

- Is your menstrual cycle often irregular? Yes No Do you have heavy menstrual periods? Yes No
- When was your last period? _____ How many tampons/ pads do you use per day? _____
- How many days do your periods last? _____
- Do you have a history of gynecological problems? Yes No If yes, please specify. _____

MEN

- Have you ever had prostate problems? Yes No
- Do you use sexual performance drugs such as Viagra, Levitra, Ciliast, etc.? Yes No

PATTERN BALDNESS CHARACTERISTICS

- What color is your hair? _____
- What characteristic best describes your natural hair? Straight Wavy Curly
- What is the texture of your hair? Fine Medium Thick
- At what age did you begin to notice hairloss? _____
- Has your hairloss or thinning increased significantly in the past five years? Yes No
- Is your hairline receding at the temples? Yes No
- Are you developing a bald spot? Yes No
- Are you experiencing diffuse thinning over the entire scalp? Yes No
- Have you consulted a doctor about your hairloss condition? Yes No
- If yes, what treatment was recommended? _____
- Have you ever had surgical hair restoration performed? Yes No
- If yes, what procedure? _____
- Have you treated your hairloss with Minoxidil (Rogaine)? Yes No
- Have you taken or are you on Propecia? Yes No
- Have you treated your hairloss with any other topical treatments? Yes No
- If yes, what? _____

PLEASE CHECK ALL THAT APPLY TO YOU CURRENTLY OR IN THE PAST.

- | | | | |
|----------------------|--|--------------------------------------|--|
| Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | High / Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Nasal Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bladder Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Vision / Eyes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Decreased circulation (fingers/toes) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chest Pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach Ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Irritations | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rashes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Gall Bladder Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV/Aids | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Yellow Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sexually Transmitted Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Severe Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizzy Spells | <input type="checkbox"/> Yes <input type="checkbox"/> No | Depression | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Paralysis/Numbness | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you answered yes to any of the above, please explain. List medications that are being used to treat the problem.

Do you or any family members have the following (please indicate relationship)?

- | | | |
|-------------------------------|--|-------------------|
| Heart trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |
| Excessive bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |
| Thyroid problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |
| Excessive bruising | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |
| Unfavorable/wide scarring | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |
| Delayed or poor healing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |
| Psychiatric or nerve problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |
| Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |
| High blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |
| Low blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |
| Other | <input type="checkbox"/> Yes <input type="checkbox"/> No | Relationship_____ |

Thank you.

4/04

Patient's signature _____ Date _____

Physician's signature _____ Date _____

Reviewed by _____ Date _____