Hair Restoration Center of Connecticut
Medical and Surgical History

Patient name: _____ **DOB:** _____ **Age:** _____

Is your scalp tender where you have hair loss? ☐ **NO** ☐ **YES**

How fast are you losing hair at this time? ☐ Stable ☐ Gradually ☐ Quickly

Which family members have hair loss? ☐ Father ☐ Mother ☐ Sibling ☐ Extended Relative ☐ N/A

Are you *allergic* to any medications? ☐ **NO** ☐ **YES**, *If yes, please describe:* _____

_____

Have you ever had or been treated for any of the following? (check all that apply)

- ☐ *Respiratory problems,* including asthma, shortness of breath or chronic lung disease
- ☐ *Cardiovascular problems*, including chest pain, high blood pressure, heart attack, angina, heart valve problems, or stroke.
- ☐ *Any dermatologic problems,* including eczema, psoriasis, dandruff, or chronic rash
- ☐ *Any type of cancer*, including skin cancer
- ☐ *Any metabolic problem* such as thyroid disease or diabetes
- ☐ *Any bleeding problems such as* nosebleeds, easy bruising or anemia
- ☐ *Any mental health concern such as* depression, anxiety or panic disorder
- ☐ *Any immune system disorder*

Please list any diseases that you have had or are being treated for that are not listed:

_____

_____

Do you take any blood thinners (Aspirin, Ibuprofen, Coumadin, Plavix, Fish Oil, etc)? ☐ **NO** ☐ **YES,** *If yes, please list below:*_____

Do you require preventative antibiotics prior to dental procedures or have you had joint replacement or heart valve replacement? ☐ **NO** ☐ **YES,** *If yes, please describe below:*_____

_____

Please list ALL prescription/non-prescription/herbal meds or supplements that you are currently taking:

_____

Please list all previous surgeries, including hair restoration procedures_____

_____

Weekly alcohol intake?_____ **Weekly cigar/cigarette use?** _____
Females only: Date of your last menstrual period? _____ Are you pregnant? _____
May we communicate with your health care provider(s) to review any medical concerns? _____

_____ _____ _____
Patient signature Physician signature Date