GABEL
HAIR RESTORATION

Please complete this questionnaire in black ink. The following information is important to your health. Please take the time to accurately and completely fill this out.

PATIENT HISTORY

Name: _____**Date of Birth**: _____

Gender: **M** **F** **Age**: _____

Hair Loss History: Age of onset of hair loss: _____
Above average hair loss recently: ☐ Yes ☐ No

What are your current hair loss concerns?

- ☐ Starting to thin
- ☐ Advanced stage of thinning
- ☐ Receding hairline
- ☐ Bald spot in the crown
- ☐ Little or no hair on top of scalp
- ☐ Thin eyebrows
- ☐ Sparse eyelashes
- ☐ Postoperative plastic surgery hair loss
- ☐ Increased shedding of hair

Other:_____

Have you experienced the following conditions?

	In the past	Currently
Scalp tenderness or pain	☐	☐
Scalp itching	☐	☐

Have you used any of the following?

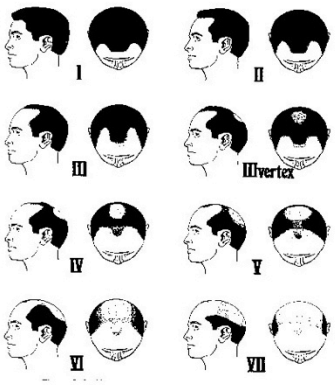
	In the past	Currently
Hair color	☐	☐
Hair perm	☐	☐
Hair piece	☐	☐
Minoxidil (Rogaine®) treatment	☐	☐
Finasteride (Propecia®) treatment	☐	☐
Shampoo for thinning hair	☐	☐
Vitamins/Minerals/Herbs	☐	☐

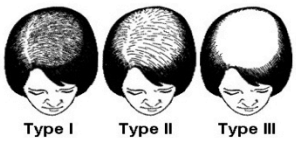
Which of your family members have/had hair loss?

- ☐ Mother
- ☐ Mother's Father
- ☐ Mother's Mother
- ☐ Father
- ☐ Father's Father
- ☐ Father's Mother
- ☐ Brother(s)
- ☐ Sister(s)
- ☐ Other(s)

Name:_____ **Date of Birth**: _____

Please circle the diagram which you feel closely matches your hair loss pattern.





Which area(s) do you wish to restore:

☐ Hairline restoration
☐ Increase in frontal density
☐ Crown coverage
☐ Stop hair loss or decrease shedding
☐ Touch-up, refinement, or correction of previous procedure
☐ Scar coverage

Please state your goals and objectives:

_____

_____

_____

Have you ever had any hair restoration procedures in the past? (If yes, please indicate date(s), area(s) transplanted, and number of grafts placed)

_____

_____

_____

Please check all referrals that apply. (Who should we thank?)

☐ Internet _____

☐ Newspaper _____

☐ Television _____

☐ Friend/Patient _____

☐ Other _____

Name: _____ **Date of Birth**: _____

Past Medical History: Please check YES or NO for every condition listed below.

YES	NO		YES	NO	
□	□	History of Alopecia Areata	□	□	Lung Disease
□	□	Low Iron	□	□	Stroke/TIA
□	□	Lupus	□	□	Kidney Problems
□	□	Hair Pulling	□	□	Diabetes
□	□	Thyroid Disease	□	□	Cancer
□	□	Polycystic Ovarian Syndrome	□	□	Rheumatic Heart Disease
□	□	Keloid Formation	□	□	History of Rheumatic Fever
□	□	Scarring	□	□	Mental Illness
□	□	Bleeding Disorder	□	□	Depression/Anxiety
□	□	HIV/Hepatitis	□	□	Asthma
□	□	High Blood Pressure	□	□	Implants
□	□	Irregular Heart Beat	□	□	Prosthetic Joints
□	□	Coronary Heart Disease	□	□	Substance Abuse
□	□	Heart Murmur	□	□	Problems with local anesthesia

Do you have any medical conditions that are not listed above?

_____

Are you presently under the care of a physician for any of the above conditions?

_____

Please list ALL surgery you have had including the date(s).

_____

_____

_____

Current Medications (please list all medications including over the counter medications; for example, aspirin or other blood thinners, vitamins, herbs, or supplements):

_____

_____

_____

Allergies to medications: _____

Social History: Current occupation: _____

Smoking: □ Never smoked

□ Previous smoker (When did you quit?_____)

□ Currently smoke _____ packs/day for _____ years

Alcohol: □ Daily □ Occasionally □ Rare □ Never

The above information is true and correct to the best of my knowledge.

_____ _____

Signature of Patient **Date**