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?

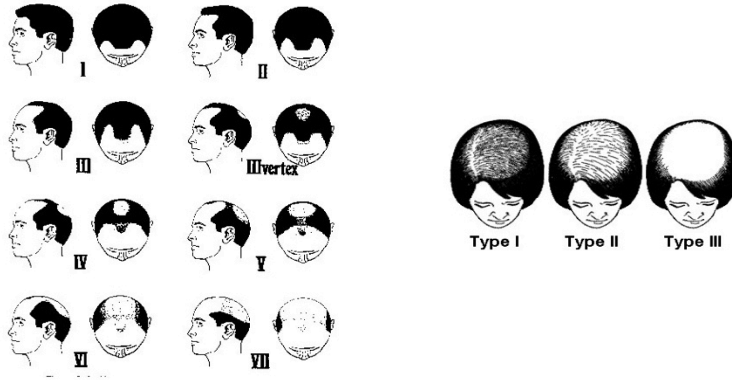
	In the past	Currently
Hair color	☐	☐
Hair perm	☐	☐
Hair piece	☐	☐
Minoxidil (Rogaine®) treatment	☐	☐
Finasteride (Propecia®) treatment	☐	☐
Shampoo for thinning hair	☐	☐
Vitamins/Minerals/Herbs	☐	☐

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**