MEDICAL HISTORY FORM

Name: _____ Age/Sex: _____ Date: _____
Address:_____ _____Single/Married
Email Add: _____Contact No: Home _____
Occupation__ _____Mobile: _____
Referred by_____
Occasionally the Asian Hair Restoration Center have items of interest such as new techniques or medications. Would you like to have notices such as these sent to your home or email address?
Yes_ _____ No_____

Please answer the following questions:

1) How long have you been having hair loss ?

2) Are you using any medication for hair loss? Yes ☐ No ☐
If yes, please list medications used for hair loss _____
_____

3) PERSONAL HISTORY**:**

Is your father bald? Yes_____ No_ _____
If so, describe the width of the remaining rim of hair: narrow wide average receding
Is anyone in your mother's family bald? Yes_____ No_ _____
If so, describe the width of the remaining rim of hair: narrow wide average receding

Do you have any brothers who are bald? Yes_____ No_____
If so, describe the width of the remaining rim of hair: narrow wide average receding

Have you ever had any of the following?

Reactions or allergies to local anesthetics such as those used by a dentist?	Yes_____ No_____
Fainting or fainting spells?	Yes_____ No_____
Do cuts on your skin heal with normal scars?	Yes _____No_____
Do you require more "freezing or numbing" at the dentist?	Yes_____ No_____
Bad reactions to any substances applied to your skin?	Yes_____ No_____
Bad reactions to Librium, Valium, steroids, antibiotics, or stitches?	Yes_____ No_____
Previous cosmetic surgery? If yes, please list:	Yes____ No_____

_____

Date of last Executive Check up:_____ __ Last PSA Value:_____

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Name of Patient: _____ **Age/Sex:** _____ **Date:** _____

Please put a circle on 'Y' (yes) and 'N' (no) for the diseases enumerated below.

Do you have a history of:

Bleeding Problems (nose bleeds, gum bleeds, easy bruising, anemia)	**Y**	**N**
Poor or abnormal healing (wide scars, raised scars, large scars, keloids, slow healing)	**Y**	**N**
Ophthalmologic (Eye Problems, cataract, glaucoma)	**Y**	**N**
Ear Problems (Ear aches, abnormal discharge, decrease hearing)	**Y**	**N**
Liver Problems (hepatitis A, B, C)	**Y**	**N**
High Blood pressure	**Y**	**N**
Heart Disease (heart attack, chest pain, arrhythmia, irregular pulse, murmur, rheumatic fever)	**Y**	**N**
Lung Disease (asthma, pneumonia, chronic bronchitis, pleurisy)	**Y**	**N**
Hormonal Disease (diabetes, thyroid problems, etc.)	**Y**	**N**
Kidney, Bladder disease, prostate problems	**Y**	**N**
Stomach disease (ulcers, heart burn)	**Y**	**N**
Neurologic Disease (Stroke, seizure, fainting, epilepsy, meningitis, neuralgia, migraine)	**Y**	**N**
Hay fever, hives, eczema	**Y**	**N**
Glaucoma	**Y**	**N**
Do you have any artificial joints, valves, metal pins	**Y**	**N**
Disorders of the immune system (arthritis, joint pains)	**Y**	**N**
Tattoos	**Y**	**N**
Blood Transfusions	**Y**	**N**
Venereal/ Sexually Transmitted Diseases (HIV)	**Y**	**N**
Emotional Problems (depression, anxiety, panic disorder, etc.)	**Y**	**N**
Rare disorders (hereditary angioedema, Malignant hyperthermia)	**Y**	**N**
Do you require more anesthetic solutions than most people?	**Y**	**N**

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- Please list history of any other medical illness not mentioned above and include the treatment

  _____
  _____
  _____
  _____

- Please list history of previous hospital admissions

  _____
  _____

- Please check the medications you are currently on
  Aspirin_____Vitamin E _____Coumadin___ Clopidogrel_____
  NSAIDS (ex.Mefenamic acid, Ibuprofen)_____
  Ticlopidine_____Warfarin_____ Heparin_____

- List all prescription and non-prescription medications, vitamins and supplements that you are using which are not mentioned above

  _____
  _____
  _____

- Do you have any allergy to medications and indicate name of drug?
  - ☐ Antibiotics _____
  - ☐ Anesthetics _____
  - ☐ Pain relievers _____ _____
  - ☐ Anti inflammatory_____
  - ☐ Ointments or creams_____ _____
    OTHERS_____

- **Weekly alcohol intake_____Weekly cigarette use_____ Other drugs_____**

Do you smoke now? yes____ no____ How many packs per day_____
Have you tried to quit? yes___ no____ What did you try?_____
Can you go an 8 hour period without smoking? yes____ no_____
If you have quit smoking, when did you quit?_____
How many packs did you smoke per day?_____
What did you use to quit?_____

- **Pertinent Family History**

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Cancer
Tuberculosis
Diabetes
Heart disease
Hypertension
Stroke
Epilepsy
HIV
Hepatitis
Jakob Kurtzfeld
Please list down any other family diseases not mentioned above:
_____
_____
_____

I attest that all information given above is accurate and correct information

Patient's Signature over Printed Name **Date**

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