SACRAMENTO HAIR DOCTOR
NALINI G. PRASAD, MD

MEDICAL HISTORY FORM

Name: _____ Date: _____

❑Allergies to medications: _____

❑Allergies to Latex? ❑Yes ❑No

❑ Past Medical Illnesses (please list): _____

_____

❑Past Surgeries (please list): _____

Medications/Medical Treatment:

RX Medications: _____

Over the Counter Medications (including herbal): _____

At what age did you first notice hair loss? _____

Have you been treated by a physician for hair loss? If yes, please state diagnosis and any medications.

_____

_____

Have you had a scalp biopsy? _____

If you are a female, have you had any blood tests for hair loss? _____

_____

Have you had prior recommendations for any treatments for hair loss? _____

_____

Lifestyle Information:

Do you consume alcohol?	❑Yes	❑No
Do you smoke?	❑Yes	❑No
Do you exercise regularly?	❑Yes	❑No

Cosmetic History (Check all that apply):

❑Facial surgery ❑Filler injections

❑ Botox injections ❑Facial peels

❑Laser Treatments (please list):_____

Additional Comments: _____

_____