

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: _____