Last Name: ____________________ First Name: ____________________ Today's Date: ______________

Birth Date: ___________________ Age:___________ Occupation: _______________________________

Home Address: ____

City:____________________________ State:__________________________ Zip:____________________

Home Phone:____________________________ Cell Phone:_____________________________________

Email Address: _____________________________________ May we contact you via email? ( )Yes ( ) No

In case of Emergency Contact:__________________________ Cell Phone:___________________________

Relationship:____

Primary Care Physician's Name: ______________________________ Phone: _______________________

Specialist's Name: ____ Phone: _______________________

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widowed ( ) Living with Partner ( ) Single

How did you hear about us? ____

Medical History

Any Known Drug Allergies: ____

Medications / Supplements Currently Taking: ____

____

Surgeries? List All and When: ____

Complications with Anesthesia: ( ) NO ( ) YES, Reaction _______________________________________

Are you currently having skin treatments or injectables done elsewhere? ( ) Yes ( ) No

If yes, what type of treatments and/or injectables?

____

What is your ethnicity? Example: Hispanic, German, Indian, etc. ___________________________________

Have you seen a dermatologist in the past year? ( ) Yes ( ) No

If yes, please list reason for visit: ____

FEMALE ONLY - Are you currently: ( ) Nursing ( ) Pregnant ( ) Planning to become pregnant

Please rate your stress level from 1-5 (5 being the highest): ______________________________

Family Hair loss:

Does anyone in your father's family have hairloss? ( ) Yes ( ) No ( ) Don't Know
Does anyone in your mother's family have hairloss? ( ) Yes ( ) No ( ) Don't Know
Do you have brothers that have hairloss? ( ) Yes ( ) No ( ) Don't Know
Are there women in your family with hairloss? ( ) Yes ( ) No ( ) Don't Know

Medical Illnesses:

( ) High blood pressure
( ) High cholesterol
( ) Hypertension
( ) Heart disease
( ) Stroke and/or heart attack
( ) Blood clot and/or a pulmonary embolism
( ) Arrythmia
( ) Any form of Hepatitis or HIV
( ) Lupus or other autoimmune disease
( ) Trouble passing urine (taking Flomax or Avodart)
( ) Cancer type:___________________________
( ) Testicular or prostate cancer
( ) Asthma / Respiratory Issues
( ) Seizures or Seizure Disorder
( ) Depression / Anxiety
( ) Arthritis
( ) Thyroid disease
( ) Diabetes
( ) Chronic liver disease (fatty liver, cirrhosis)
( ) Fibromyalgia
( ) Psychiatric disorder

Habits:

( ) I smoke cigarettes or cigars ________ per day
( ) I use marijuana ________ per week
( ) I drink alcoholic beverages ________ per week
( ) I use caffeine ________ per day
( ) I have a history of substance / drug abuse

Additional Symptoms or Concerns you'd like your provider to know:

We value your business and ask that you respect our business scheduling policies. Please notify us at least 24 hours in advance of any cancellation. All cancellations with less than 24-hour notice and no-show appointments are subject to a $75 cancellation fee.

Print Name Signature Date