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Patient Questionnaire

Last Name:	**First Name:**	**DOB:**	☐ **F** ☐ **M**

Marital status: ☐ Single ☐ Married	**Occupation:**	**Weight (lbs):**	**Height:**

PCP (Primary Care Physician):	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Immunizations (Include approximate year or age)

☐ Tetanus ☐ Hepatitis A ☐ Covid Vaccine(s) (Qty:) _____
☐ Influenza (Flu) ☐ Hepatitis B ☐ Are you tested positive for Hepatitis C or HIV?

Past or Present Medical History: (check all that apply to you)

☐ Alcohol/ Drug problem	☐ Diabetes	☐ Hyperthyroidism (high)	☐ Seizure Disorder
☐ Anemia	☐ Emphysema/COPD	☐ Kidney Disease	☐ STD/ sexual infection
☐ Anxiety	☐ Heart – Attack	☐ Liver Disease	☐ Sleep Apnea
☐ Asthma	☐ High Blood Pressure	☐ Prostate problem	☐ Heart Murmur
☐ Atrial Fibrillation	☐ High Cholesterol	☐ Psychiatric- Depression	☐ Migraines
☐ Blood Clots	☐ Hypothyroidism (low)	☐ Ulcers of the Stomach	☐ Hepatitis
☐ Cancer (if Yes, Type:) _____			☐ Positive TB test

☐ Other: _____

SEXUAL HEALTH

☐ Sexually active ☐ Not currently sexually active Erectile Dysfunction? ☐ No ☐ Yes

children: **For Women:** (# pregnancies:)

Surgeries (Include Year or Age at time of surgery) and Family Health aHistory

☐ Past Surgical History:

☐ Family Health History Father : Mother :

HAIR LOSS HISTORY

☐ Previous Hair Restoration or Hair Treatment (If Yes, Explain):
☐ PRP

Age at which your hair loss starts: Do you still losing your hair or it stopped (when it stopped):

Are you using any of these products? ☐ Biotin (If yes, For Howlong?) _____ ☐ Finasteride (Propecia) (If yes, For Howlong?) _____
☐ Minoxidil (Rogaine) (If yes, For Howlong?) _____

MEDICATIONS: List prescribed and over-the-counter medications.

Current Medication (Including OTC) :

MEDICATION, FOOD and ENVIRONMENTAL ALLERGIES

Do you have any allergies? (including medication or food) : ☐ Medication _____
☐ Latex ☐ Pollen ☐ Other _____ ☐ Food _____

Tobacco	**Cigarette use:**	☐ Never	☐ Former smoker. Quit date or age:	
		☐ Current smoker----	# packs/day:	# years:
	Other tobacco use:	☐ Pipe	☐ Cigars	☐ Chewing tobacco

Alcohol	Do you drink alcohol? ☐ No ☐ Yes (If Yes) Please write amount:
Drugs	Do you any drug(s)? ☐ No ☐ Yes (If Yes) Please write amount:

I hereby declare that the information provided is true and correct. _____
Signature