Medi Tresse

MEDICAL HAIR REJUVENATION FOR WOMEN

Patient Information

Name: _____ Date of Birth: _____ (Example MM/DD/YYYY)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

How did you hear about us: _____

Primary Care Physician Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Emergency Contact: _____ Phone: _____

Relation to Patient: _____

Patient Communication Consent Form

I authorize the physician at Medi Tresse and her staff to leave messages for me when I am unavailable.

I authorize the physician at Medi Tresse and her staff to discuss my healthcare information (which may include history, diagnosis, labs, test results, treatment and other health information) with other medical professionals as appropriate for my medical care.

_____ _____

Patient Signature Date/Time

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Medical History Form

Patient Name: _____ Date: _____

Do you have or have you had any of the following conditions:

Y/N	Condition	If Yes, Please Clarify Further
	Neurological Disease	
Y/N	Stroke	
Y/N	Seizure	
Y/N	Migraine	
Y/N	Multiple sclerosis	
Y/N	Fainting	
Y/N	Numbness of the scalp	
Y/N	Chronic Pain	
	Autoimmune disorders	
Y/N	Lupus	
Y/N	Rheumatoid arthritis	
Y/N	Scleroderma	
	Skin disease	
Y/N	Psoriasis	
Y/N	Eczema	
Y/N	Keloid/hypertrophic scarring	
Y/N	Latex allergy	
Y/N	Frequent cold sores/herpes	
Y/N	Skin Cancer	
	Pulmonary disorders	
Y/N	Emphysema/COPD	
Y/N	Sarcoidosis	
Y/N	Asthma	
	Heart Disease	
Y/N	Irregular pulse	
Y/N	Chest pain	
Y/N	Pacemaker	
Y/N	Poor circulation	
Y/N	Raynaud's disease	
	Stomach Disease	
Y/N	Ulcers	
Y/N	Liver disease	

Y/N	Condition	If Yes, Please Clarify Further
	Blood disorders	
Y/N	Anemia	
Y/N	Easy bruising	
Y/N	Low platelets	
Y/N	Nose bleeds	
Y/N	Easy Bleeding	
	Endocrine Disease	
Y/N	Diabetes	
Y/N	Thyroid disease	
Y/N	Adrenal disease	
Y/N	Polycystic ovary syndrome	
	Psychiatric disorders	
Y/N	Anxiety	
Y/N	Depression	
	Chronic Infections	
Y/N	HIV /AIDS	
Y/N	Chronic Hepatitis	
	Other	
Y/N	Cancer or cancer treatments/radiation therapy	

Have you taken or do you currently take any of the following medications:

Y/N	Medical History	If Yes, Please Clarify Further
Y/N	Over The Counter Medications	
Y/N	Herbal Supplements	
Y/N	Retin-A or Generics	
Y/N	Blood Thinner (Coumadin, Asprin)	
Y/N	Acne Medication	
Y/N	Oral Contraceptive	
Y/N	Accutane (if yes please list date completed)	
Y/N	Antibiotics	
Y/N	Prescription Medications (If yes please list all current prescription medications)	

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Are you allergic or have you had a "bad reaction" to any of the following:

Y/N	Medical History	If Yes, Please Clarify Further
Y/N	Shellfish/Seafood	
Y/N	Xylocaine	
Y/N	Skin Tape	
Y/N	Penicillin	
Y/N	Sulfa Antibiotics	
Y/N	Codeine	
Y/N	Latex	
Y/N	Medication Allergies	
Y/N	Other	

Please list any surgeries and the date of the surgery:

Surgery	Date (MM/YYYY)

Patient Signature

Date

MEDICAL HAIR REJUVENATION FOR WOMEN

Hair Loss Evaluation Form

Patient Name: Age: Date of Birth: / /

Hair Loss History

At what age did you first notice hair loss?_____

How fast are you losing hair at this time? (Circle one) Stable/Gradually/Quickly

Which family member(s) also have hair loss (list all that apply)? _____

Have you ever had hair restoration surgery (Date, Number Grafts Physician)? _____

_____

Where is your hair loss most bothersome? (Circle all that apply) The front/The crown/Everywhere

What concerns you most about hair loss? _____

_____

_____

_____

Are you on Rogaine (Minoxidil)? If yes, when did you begin? _____

What other products or treatments have you used to try to improve your hair? _____

_____

_____

What are your goals and expectations? Please describe what you would like to accomplish with future treatments? _____

_____

_____

_____

Health Questionnaire

1. Do you have a history of low iron? Y/N
   If yes, are you taking supplementation?_____
2. Have you had a serious illness during the past year? Y/N
   If yes, approximately how long ago? _____
3. Have you been hospitalized during the past year? Y/N
   If yes, when were you hospitalized? _____
4. Have you been under a severe amount of stress over the past six months? Y/N

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5. Have you started any special diets during the past year? Y/N
   If yes, which type of diet are you currently on? _____
6. Have you ever had excessive shedding? Y/N
   If yes, for how long and when did this occur? _____
7 Are there any types of medications that you were taking when you noticed your hair falling out? Y/N
   If yes, please list the medication(s). _____
8. Do you take any supplements or vitamins? Y/N
   If yes, please list. _____
9. Do you get your menstrual period? Y/N
   If yes, how often does your period come and how many days does it last? _____
10. Have you been pregnant during the past year? Y/N
   If yes, when did the pregnancy end? _____
11. Have you ever taken hormones or oral contraceptives? Y/N
   If yes, please list. _____
12 Have you ever had issues with fertility? Y/N
13 Do you have unwanted or excessive hair growth anywhere on the body? Y/N
   If yes, where is it located? _____
14 Have you had blood work checked to evaluate your hair loss problem? Y/N
   If yes, when? _____
   If yes, did you bring a copy with you? _____
15 Does your scalp itch or sometimes burn or hurt? Y/N
16 Have you gained or lost any weight recently? Y/N

_____ _____

Patient Signature Date