ARMANI MEDICAL

Patient questionnaire

Name: _____

Date: _____ Age: _____ DOB: _____

Profession: _____

Address: _____

City: _____ State: _____ zip: _____

Best contact telephone number: _____

Personal email: _____

Emergency contact Name: _____

Emergency contact phone: _____

Relation: _____

How did you find out about us? _____

If through the internet which terms did you search for?

_____

What is your main area of concern regarding your hair loss?

_____

How long have you noticed thinning or shedding? _____

Is there a family history of baldness or thinning (if so who)?

_____

Have you used any medications, lotions or foams to treat your hair loss?

_____ Since: _____

_____ Since: _____

_____ Since: _____

Please list any previous Hair Restoration or scalp surgeries below:

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Other Past Surgeries (non Scalp related)

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

History of HIV, Hepatitis, liver disease, or bleeding disorders:

_____

Please list all previously diagnosed medical conditions:

_____

_____

List all medications and herbs you are currently taking:

_____

_____

Do you have Allergies to any **Medications** or other allergies including **Tape or Latex**?

_____