Armani Medical

Name:_____

Date:_____ Age:_____ DOB:_____

Profession:_____

Address:_____

City:_____State_____ Zip code:_____

Best Contact Number:_____

Personal Email:_____

Emergency Contact Name:_____

Phone Number: _____Relation:_____

Pharmacy name and phone number:_____

How did you find out about us?_____

If through the internet what term(s) did you search for?_____

Which area of the scalp are you most concerned about? (Front, top, or Crown)?_____

How long have you noticed hair thinning?_____

Is there a family history of thinning or baldness?_____

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

_____ Used from date _____-_____ Side effects?_____

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Have you had a hair restoration or scalp surgeries before?

Type: _____Date:_____

Number of grafts:_____ Type:_____Date:_____

Number of grafts:_____ Type:_____Date:_____

Other surgeries? (non-scalp related)

_____Date:_____

_____Date:_____

Please list all previously diagnosed medical conditions:

_____

_____

Any history of artificial joints, valves, etc.?_____

Do you or your family have a history of poor healing/scaring or Keloid formation?

_____

Do you have a problem with seeing needles or blood (any history of fainting)?

_____

Are you a smoker? _____

History of HIV, Hepatitis, liver disease or bleeding disorders?_____

List all medications and herbs you are currently taking:

_____

_____

_____

Do you have any allergies to any medications or other allergies including tape or latex?

_____

_____