

# Hair Restoration Center of Connecticut

## Medical and Surgical History

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_ age: \_\_\_\_

Are you *allergic* to any medications? \_\_\_\_ No \_\_\_\_ Yes

If yes, please circle or list below and state reaction:

Penicillin \_\_\_\_ Erythromycin \_\_\_\_ Codeine \_\_\_\_ Lidocaine \_\_\_\_\_

Other: \_\_\_\_\_

Have you ever had or been treated for any of the following? (please circle)

- Respiratory problems, including asthma, shortness of breath or chronic lung problems
- Cardiovascular problems, including chest pain, high blood pressure, heart attack, angina, heart valve problems, or stroke
- Any dermatologic problems, including eczema, psoriasis, dandruff, or chronic rash
- Any type of cancer, including skin cancer
- Any metabolic problem such as thyroid disease or diabetes

Please list any diseases that you have had or are being treated for that are not listed:

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Please list ALL prescription, non-prescription, herbal medications or supplements that you are currently taking:

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Please list all previous surgeries, including hair restoration procedures

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Do you drink alcohol? \_\_ yes \_\_ no If yes, approximately how many drinks/week? \_\_\_\_

Do you smoke? \_\_ yes \_\_ no If yes, approximate amount? \_\_\_\_

Females only: Date of your last menstrual period? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Physician signature

\_\_\_\_\_  
Date