

Last Name _____ First _____ MI _____ Date _____

Please Answer the Following Questions as Completely as Possible

(If any aspect of your health changes, please let us know.)

How is your health in general? Please circle: EXCELLENT GOOD FAIR POOR

Are you allergic to ANY medicines, drugs, collagen, sulfa, or chromium? NO YES
Please list: _____

Have you ever had ANY reaction to Novocaine, Xylocaine, Adrenaline, Penicillin, other Antibiotics, Valium, Codeine, any other pain medicine or foods? NO YES
Please describe: _____

List ALL medicines or drugs you take either regularly or occasionally: (including Accutane, Propecia, Rogaine, Aspirin, Motrin, Advil, Plavix and/or Vitamins) _____

Have you ever had Hepatitis, Liver or Kidney problems, Diabetes, Asthma, High Blood Pressure, Heart Disease, Irregular Heart Beats, Rheumatic Fever, HIV/AIDS, Hepatitis, Thyroid Disease, Phlebitis, Ulcers, Glaucoma, Seizures, Sleep Apnea, Fainting, Emotional, Drug, or Psychiatric problems? NO YES
Please list and explain: _____

Have you or any members of your family had either Prostate Disease or Prostate Cancer? NO YES
If Yes, please explain _____

Please list ALL medical problems: _____

Please list ALL operations and hospitalizations with dates (including Hair transplants, Scalp reductions, and Prostate surgery) _____

Present Age? _____ At what age did your hair loss begin? _____
What is your Height? _____ Weight? _____
How much alcohol do you drink per day? _____
How many packs of cigarettes do you smoke per day? _____
Have you had recent lab tests for HIV or Hepatitis? NO YES
Dates and Results: _____

Have you ever had problems healing? NO YES
Do you have stretched scars, raised scars, thick scars, or keloids? NO YES
Have you been advised to take antibiotics prior to surgery or dental work? NO YES
Have you ever had excessive bleeding during surgery or any other time? NO YES

If you answered YES to any of the above, please specify: _____
