Hair Sciences Center
OF COLORADO

Name_____Date_____

Legal name if different than above _____

Preferred Pronoun: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their ☐ Other

☐ Mr. ☐ Ms. ☐ Mx. ☐ MD ☐ DO ☐ DDS ☐ PhD

SEX GENDER ☐ Male ☐ Female ☐ Intersex ☐ Transgender ☐ Other

Address _____

City/State/Zip_____ Age_____

Birthdate_____ Marital Status _____ Occupation_____

Phone Numbers: Home:_____ Business:_____ Cell:_____

E-mail address_____

How did you hear about Dr.Harris?_____

Emergency Contact_____

Name of local family doctor_____

Occasionally the Hair Sciences Center of Colorado has items of interest such as techniques or medications. Would you like to have notices such as these sent to you? (please mark one or two below)

Home_____ Email _____ Neither _____

Family Hairloss:

Does anyone in your father's family have hairloss? Yes_____ No_____ Don't know_____

Does anyone in your mother's family have hairloss? Yes_____ No_____ Don't know_____

Do you have brothers that have hairloss? Yes_____ No_____ Don't know _____

Are there women in your family with hairloss? Yes _____ No_____ Don't know _____

Have you ever had any of the following?

Reaction or allergies to local anesthetics such as those used by a dentist? Yes__ No__
Bleeding disorders, frequent nosebleeds, easy bruising, or bleeding longer than most people when cut ? Yes__ No__
Fainting or fainting spells? Yes__ No__
Do cuts on your skin heal with normal scars? Yes__ No__
Do you require more "freezing or numbing" at the dentist? Yes__ No__
Reactions to any substances applied to your skin? Yes___ No__

Previous hair transplants? If yes, please list number of grafts and sessions Yes__ No__

PATIENT HISTORY

Do you have restless leg syndrome? Yes____ No___

Are you taking medication or being treated for restless-leg syndrome? Yes____ No ___

Do you have any problems or been diagnosed with a disease that may prevent you from sitting or lying still for long periods of time? Yes____ No____

Have you had or currently have any problems or diseases in the following areas?
If so, please briefly describe:

Cancer_____
Heart problems_____
Sleep Apnea_____
Respiratory problems_____
Epilepsy_____
Tuberculosis_____
Hypertension_____
HIV_____
Diabetes_____
Stroke_____
Hepatitis_____

Are you or have you ever been a smoker?

If yes, please indicate the following:

Do you smoke now? Yes____ No____ How many packs per day_____

Can you go an 8 hour period without smoking? Yes_____ No_____

Please list any issues with the following areas:

Scalp disease:_____

Head:_____

Eyes:_____

Ears:_____

Mouth:_____

Nose:_____

Gastrointestinal:_____

Cardiac:_____

Genitourinary:_____

List All Medications including hormone treatments (prescription and over-the-counter) you are currently taking:

_____For:_____

_____For:_____

_____For:_____

_____ For:_____

_____ For: _____

Previous Hospital Admissions and/or Surgeries:

_____

_____

_____

Allergies to Medications:

_____Reaction:_____

_____Reaction:_____

_____Reaction:_____

Allergies or sensitivity to Aspirin, NSAIDS or Ibuprofen:

_____ Reaction:_____

Allergies to Foods:_____ Reaction:_____

_____

Drug Frequency:

Vitamins: Never occasional frequently daily

Please list: _____

Herbs: Never occasional frequently daily

Please list: _____

Sedatives: Never occasional frequently daily

Valium: Never occasional frequently daily

Sleep aids: Never occasional frequently daily

Anti-anxiety Medications: Never occasional frequently daily

Have you ever been addicted to any drugs? Yes_____ No_____

Have you tested positive for any of the following?

HIV: Yes_____ No____

Diabetes: Yes____ No____

Hepatitis A: Yes____ No____

Hepatitis B: Yes___ No____

Hepatitis C: Yes____ No____

Prolonged bleeding times: Yes____ No____

Date of last lab (blood work) screening?_____

Have you ever experienced jaundice (yellowing of the skin or eyes)? Yes____ No__