Hair Sciences Center

OF COLORADO

## Patient History

Name: ______________________ Date: ______________

Address______________________ Occupation ______________

City/State/zip______________ Birthdate______________ Marital Status ______________

Phone Numbers: Home __________ Business ______________ Cell ______________

Referred by______________________ E-mail address ______________

Name and address of local family doctor: ______________________________

______________________________

Name and address of dentist: ______________________________

______________________________

Occasionally the Hair Sciences Center of Colorado have items of interest such as new techniques or medications. Would you like to have notices such as these sent to your home or email address? Yes ________ No ________

**PERSONAL HISTORY:**

**Is your father bald?** Yes __________ No __________
If so, describe the width of the remaining rim of hair: narrow wide average receding

**Is anyone in your mother's family bald?** Yes __________ No __________
If so, describe the width of the remaining rim of hair: narrow wide average receding

**Do you have any brothers who are bald?** Yes __________ No __________
If so, describe the width of the remaining rim of hair: narrow wide average receding

**Have you ever had any of the following?**

| | | |
|---|---|---|
| Reactions 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 ________ |
| Bad reactions to any substances applied to your skin? | Yes ________ | No ________ |
| Bad reactions to Librium, Valium, steroids, antibiotics, or stitches? | Yes ________ | No ________ |
| Previous cosmetic surgery? If yes, please list: | Yes ________ | No ________ |

______________________________

**Please indicate all illnesses you have had:**

| | | |
|---|---|---|
| Pneumonia ________ | Bone/Joint disease ________ | Influenza ________ |
| Neuritis/Neuralgia ________ | Pleurisy ________ | Polio ________ |
| Rheumatic fever ________ | Meningitis ________ | Heart Disease ________ |
| Nephritis ________ | Arthritis ________ | Venereal Disease ________ |
| Anemia ________ | Jaundice ________ | Hepatitis ________ |
| Epilepsy ________ | Migraines ________ | Tuberculosis ________ |
| Diabetes ________ | Cancer ________ | HIV ________ |
| Jakob-Kurtzfeld Disease ________ | | |

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## Patient History continued

**Has any blood relative ever had:**

Cancer ______ Tuberculosis ______ Diabetes ______
Heart Disease ______ Hypertension ______ Stroke ______
Epilepsy ______ HIV ______ Hepatitis ______
Jakob-Kurtzfeld ______

**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? ______

Have you tried to quit? yes ______ no ______ What did you try? ______

Can you go an 8 hour period without smoking? yes ______ no ______

If you have quit smoking, when did you quit? ______

How many packs did you smoke per day? ______

What did you use to quit? ______

______

**Within the past year, have you had any of the following:**

**Head**
Frequent or severe headaches ______
Dizziness or change of position ______
Unconscious spells ______

**Eyes**
Blurred or double vision ______
Cataracts ______
Glaucoma ______
Changes in vision ______
Do you wear glasses/contacts? ______

**Ears**
Frequent Earaches ______
Discharge from ears ______
Ringing in ears ______
Decrease in hearing ______

**Mouth**
Persistent hoarseness ______
Difficulty swallowing ______
Enlarged glands ______
Recurrent sore throats ______
Sores in the mouth ______
Chronic cough ______
Habitual smoking ______

**Nose**
Recurrent nose bleeds ______
Recurrent head colds ______
Sinus trouble ______
Hay fever ______

**Gastrointestinal**
Recurrent stomach pains ______
Ulcers ______
Belching or heartburn ______
Nausea or vomiting ______
Vomiting blood ______
Abdominal cramping ______
Black/bloody stools ______
Hemorrhoids ______
Rectal pain with stools ______

**Cardiac/Respiratory**
Angina Pectoris ______
Chest pain not identified ______
Pain in arms ______
Shortness of breath ______
Purple lips/extremities ______
Palpitations/flutters ______
High/Low blood pressure ______
Swelling of hands/ankles ______
Asthma ______
Emphysema ______

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## Patient History continued

**Genitourinary**
Pain during urination ______________
Difficulty starting urination ___________
Blood in the urine ______________
Voiding small amounts ____________
Stress incontinence ______________
Pain in kidney/bladder ____________
Sexual dysfunction ______________

**Neuromuscular**
Recurrent back pain ______________
Chronic backaches ______________
Joint pain ____________________
Swelling/redness of joints __________
Muscle spasms _________________
Trembling in extremities ___________
Weakness in joints ______________

**Date of last Physical:** ____________

**Last PSA Value:** ________________

**Medications Now Taking:**

____________________ for ______________________________
____________________ for ______________________________
____________________ for ______________________________
____________________ for ______________________________
____________________ for ______________________________

**Previous Hospital Admissions:**

____________________ for ______________________________
____________________ for ______________________________
____________________ for ______________________________
____________________ for ______________________________
____________________ for ______________________________

**Allergies to Medications:**

____________________ Reaction ___________________________
____________________ Reaction ___________________________
____________________ Reaction ___________________________
____________________ Reaction ___________________________
____________________ Reaction ___________________________

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## Patient History

**Allergies To Food:**

_______________________________________________

**Drug Frequency**

| | | | | |
|---|---|---|---|---|
| Laxatives: | never | occasional | frequently | daily |
| Vitamins: | never | occasional | frequently | daily |

Please list: _______________________________________________

_______________________________________________

| | | | | |
|---|---|---|---|---|
| Herbs: | never | occasional | frequently | daily |

Please list: _______________________________________________

_______________________________________________

| | | | | |
|---|---|---|---|---|
| Sedatives: | never | occasional | frequently | daily |
| Aspirin: | never | occasional | frequently | daily |
| Valium: | never | occasional | frequently | daily |
| Sleepers: | never | occasional | frequently | daily |

Have you ever been treated for a drug habit? Yes _________ No_________

Have you ever taken Insulin for diabetes? Yes _________ No_________

Have you ever had hormone replacement therapy? Yes _________ No_________