IHTI

PATIENT INFORMATION

PLEASE COMPLETE THE FOLLOWING INFORMATION
(If there are any changes in the future, please let us know)

Date ________/________/________ Seminar Location____

Last Name: _______________________________ First Name: _______________________________ MI: __________

Home Address: ____ Apt.____________

City: ____ State: ___________ Zip: ____________________

Home Phone: (______) ___________-____________ Work Phone: (______) _____________-_________________

Cell Phone: (______) __________-______________ Occupation: _______________________________________

E-Mail Address: ____ Date of Birth: _______/_______/__________

You may contact me at: HOME WORK EMAIL CELL ALL (please circle)

Sex: M F Marital Status: M S D W (please circle) Age: ________

Please circle:

Have you visited our web site?	Yes	No
Have you attended a PIHTI Seminar?	Yes	No
Have you had a previous consultation for hair restoration surgery by another medical group?	Yes	No

Please circle the ONE source that was most responsible for you coming here.

Physician Family Friend Hair-Stylist Radio

TV Newspaper Magazine Internet Other: _______________________

What SPECIFIC source TV/radio station, newspaper/ magazine, internet site are you referring to above?

Name: ____

If you were referred by a physician, friend or another patient of IHTI whom may we thank for the referral?

Name: ____

Please type or circle the Norwood Scale that most reflects your current hair loss: What age did hair loss begin?

Norwood I

Norwood II

Norwood II A

Norwood III

Norwood III A

Norwood IV

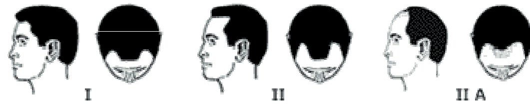
Norwood V

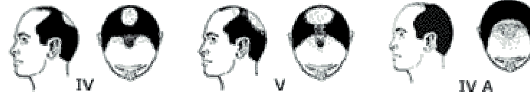
Norwood IV A

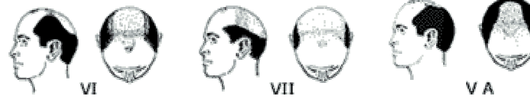
Norwood VI

Norwood VII

Norwood V A







IHTI

MEDICAL HISTORY

PLEASE COMPLETE THE FOLLOWING INFORMATION

Last Name___________________________ First__________________ MI_____ Date____________

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETE AS POSSIBLE

(Please circle "NO" or "YES", and if YES please provide details where appropriate. If any aspect of your health changes, please let us know.)

Please explain your goals and expectations for your hair transplant, inc. FIT, STRIP, areas, be specfic:

____

____

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

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

Have you ever had **ANY** reaction to Novocain, 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 Rogaine, Aspirin, Motrin, Advil, or Vitamins)____

____

Have you ever had Hepatitis, Liver or Kidney problems, Diabetes, Asthma, High Blood Pressure, Heart Disease, Irregular Heart Beats, Rheumatic Fever, Thyroid Disease, Phlebitis, Ulcers, Glaucoma, Emotional or Psychiatric problems? NO YES
Please list and explain:____

Please list **ALL** medical problems: ____

____

Please list **ALL** operations and hospitalizations with dates (including hair transplants, scalp reductions, and hair systems etc.) ____

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 ever been advised by a physician or a health care provider that you should take antibiotics prior to surgical procedures? NO YES

Have you ever had excessive bleeding during surgery or any other ti b NO YES

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

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