FEMALE HAIR LOSS
MEDICAL HISTORY FORM

SURNAME: *FIRST NAME:* *MIDDLE INITIAL:*

DATE OF BIRTH: *AGE:* *OCCUPATION:*

ADDRESS:

POST CODE:

TEL (DAY): *TEL (EVE):* *MOBILE:*

E-MAIL: *FAX:*

AS FAR AS YOU KNOW, DO YOU SUFFER FROM OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (PLEASE TICK)

	YES	NO		YES	NO		YES	NO
HEART DISEASE			IRON DEFICIENCY			HIGH BLOOD PRESSURE		
LUNG DISEASE			FAINTING SPELLS			DIABETES MELLITIS (HIGH BLOOD SUGAR)		
KIDNEY DISEASE			INFERTLITY			RECENT ILLNESS, TRAUMA OR SURGERY		
LIVER DISEASE			SYPHILLIS			EXCESSIVE WEIGHT LOSS OR GAIN		
STOMACH ULCERS			CONVULSIONS			ABNORMAL PREGNANCIES		
FACIAL ACNE						EXCESSIVE FACIAL OR BODY HAIR		

	YES	NO
PSYCHIATRIC OR PSYCHOLOGICAL DISORDER? E.G. DEPRESSION OR HAVE YOU HAD REASON TO SEE A DOCTOR REGARDING SUCH A MATTER		
HAYFEVER, ASTHMA OR ECZEMA? IF YES, GIVE DETAILS		
REACTIONS OR ALLERGIES TO LOCAL ANAESTHETICS SUCH AS THOSE USED BY A DENTIST		
REACTIONS OR ALLERGIES TO ANY DRUGS? E.G. PENICILLIN IF YES, GIVE DETAILS		
ALLERGIES TO ANY SUBSTANCES OR MATERIAL APPLIED TO YOUR SKIN? IF YES, GIVE DETAILS		
BLEEDING DISORDERS THAT CAUSE YOU TO BRUISE EASILY, HAVE NOSEBLEEDS MORE OFTEN THAN NORMAL OR BLEED MORE THAN MOST PEOPLE WHEN YOU ARE CUT		

HAVE YOU IN THE PAST BRAIDED YOUR HAIR OR ACQUIRED A STYLE THAT PULLED YOUR HAIR TIGHTLY?		
HAVE YOU RECENTLY CHANGED YOUR DIET TYPE? E.G. WEIGHT LOWERING OR VEGETARIAN		
DO YOU SMOKE? IF YES, HOW MANY A DAY?		

DO YOU HAVE A HISTORY OF IRREGULAR MENSTRUAL CYCLES (PERIODS)?		
ARE THEY HEAVY?		
WHEN WAS YOUR LAST PERIOD?		
IF YOU HAVE RECENTLY GIVEN BIRTH, WHEN WAS YOUR CHILD BORN?		

DO YOU TAKE ANY MEDICATIONS (INCL. CONTRACEPTIVE PILL)? IF YES, PLEASE NAME THEM WITH THE DOSE		
DO YOU TAKE DIETARY SUPPLEMENTS, VITAMINS OR HERBAL PRODUCTS? IF YES, PLEASE NAME THEM		

HAVE YOU BEEN TESTED FOR HIV (AIDS) OR HEPATITIS INFECTION? IF YES, WHAT WAS THE RESULT?		

DO CUTS ON YOUR SKIN HEAL WITH **UNSIGHTLY** SCARS?		

DO YOU HAVE ITCHY, FLAKY OR DRY SCALP?		
DO YOU SHAMPOO YOUR HAIR DAILY? IF NOT, HOW OFTEN?		
DO YOU USE CONDITIONER AFTER EACH WASH? IF NOT, HOW OFTEN?		
WHICH SHAMPOO/CONDITIONER PRODUCTS DO YOU NORMALLY USE?		

YOUR GENERAL PRACTITIONER (FAMILY DOCTOR):

NAME: ______________________________

ADDRESS: ______________________________

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I Declare, that all the above information is true to the best of my knowledge
I also understand that my first consultation with the doctor is subject to a fee paid on the day

Signed: ______________________________ Date: ________________