GRECO MEDICAL GROUP ✦ GRECO DERMATOLOGY

Hair Restoration Intake Form

(Please fill out and email back to drjoe@grecodermatology.com, fax to 941-667-5544, or bring with you to your visit)

Patient Name:			**Date:**
DOB:	Age	Allergies: ❑Yes ❑NKDA; If yes, please list:	
Home Address:			Apt #
City:	State:		Zip:
Home Phone:		Cell Phone:	
Work Phone:		Occupation:	
E-Mail:		Spouse/Partner Name:	
Preferred method(s) of contact	❑Cell ❑Text ❑Email ❑Home ❑Work		
How did you first hear about us?			
Name of Person to Thank For Referral (if applicable):			
What resources have you used to learn about hair loss?			
What amount of research have you done on hair loss? ❑Minimal ❑Moderate ❑Extensive			
What type of treatment(s) are you interested in? ❑Surgical ❑Non-Surgical ❑Regenerative ❑Medical			

Do you have or have you ever had the following conditions?

Heart disease/murmur	❑Yes ❑No	High blood pressure	❑Yes ❑No
Pacemaker	❑Yes ❑No	Defibrillator	❑Yes ❑No
Polycystic Ovarian Syndrome	❑Yes ❑No	Thyroid Disorders	❑Yes ❑No
Lung Disease	❑Yes ❑No	Liver Disease	❑Yes ❑No
Kidney Disease	❑Yes ❑No	Infectious Disease	❑Yes ❑No
Organ Transplant	❑Yes ❑No	Immunosuppression	❑Yes ❑No
Bleeding Disorder	❑Yes ❑No	Diabetes	❑Yes ❑No
Pregnant/Breastfeeding	❑Yes ❑No	Artificial Joints	❑Yes ❑No
Neurological Disease	❑Yes ❑No	Anxiety/Depression/Panic d/o	❑Yes ❑No
Abnormal Iron Levels	❑Yes ❑No	Abnormal Vitamin D levels	❑Yes ❑No
HIV+/Hepatitis/Other Inf Dz	❑Yes- ❑No	Poor Wound Healing	❑Yes ❑No

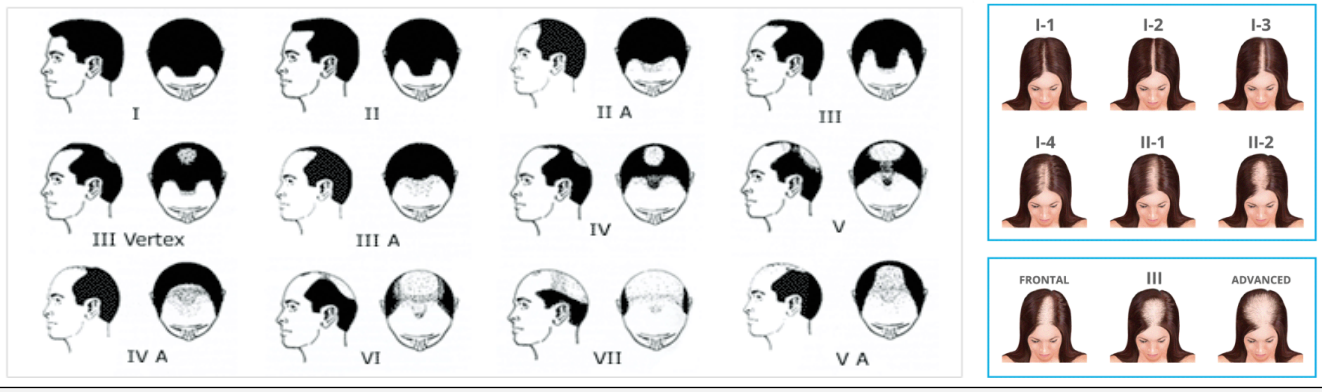
Personal History of Skin Cancer? ❑Yes ❑No	❑Basal Cell Carcinoma ❑Squamous Cell Carcinoma ❑Melanoma
History of Cancer (other than skin) ❑Yes ❑No; If yes, list diagnosis, date of diagnosis and treatment(s) undertaken:	
History of Autoimmune conditions ❑Yes ❑No; If yes, please describe here:	
Do you take blood thinners? ❑Yes ❑No	If yes, ❑Aspirin ❑Plavix ❑Coumadin ❑Other:
Do you take antibiotics before dental work or other procedures? ❑Yes ❑No; If yes, list why:	
Any other medical problems we need to be aware of? ❑Yes ❑No:	

Which relatives have hair loss?

❑Father ❑Mother ❑Grandfather/Grandmother ❑Brother/Sister ❑Uncles/Aunts ❑None

On the following diagram (Norwood/Ludwig Classification of Hair Loss) please mark as follows:

Place an A next to the hair loss pattern that is closest to **what you have now**.
Place a B next to the hair loss pattern that you might progress to **in the future (20-40 years)**.
Place a C next to the hair loss pattern that is closest to your **relative with the most hair loss**.



Select the description below that best describes your present hair condition in each area of your scalp

Hairline	❑Normal	❑Thinning	❑Very Thin	❑Bald
Frontal Area	❑Normal	❑Thinning	❑Very Thin	❑Bald
Top (Middle)	❑Normal	❑Thinning	❑Very Thin	❑Bald
Crown (Back)	❑Normal	❑Thinning	❑Very Thin	❑Bald

Hair Characteristics (Please Select)

Hair Color	❑Blonde	❑Red	❑Brown	❑Black	❑Salt/Pepper	❑White
Skin Color	❑Fair	❑Medium	❑Dark			
Hair Curl	❑Straight	❑Slight Wave	❑Wavy	❑Curly		
Hair Thickness	❑Very Fine	❑Fine	❑Medium	❑Med Coarse	❑Coarse	

Past Hair Transplant History (if applies): FUT/FUE - Date - Number of Grafts - Surgeon

Surgery #1:

Surgery #2:

Surgery #3:

Current Hair Restoration Goals:

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Making a choice to do something about your hair loss is a very important decision. It is important to feel comfortable and well educated about your options. The following information will help us in the process.

At what age did your hair loss begin?		Did It begin gradually?	❑Yes ❑No	Did it begin rapidly?	❑Yes ❑No
At what pace is your hair loss currently progressing					❑Rapid ❑Moderate ❑Slow
Did you experience any illness, stressful event, or major life change around the time of hair loss?					❑Yes ❑No
Are you currently experiencing any illness, stressful event, or major life change? If yes, please describe:					❑Yes ❑No
Is the hair - **Shedding** (hair that falls out and you can see the hair bulb) &/or - **Breaking** (hair that falls out without visible hair bulb) &/or - **Thinning** (noticeable loss of hair density without finding shedding/breaking hair)					❑Shedding ❑Breaking ❑Thinning
If shedding/breaking, where do you find the hair? ❑Shower/Tub ❑Sink ❑Brush/Comb ❑Throughout the house ❑Work					
How many hairs do you estimate you lose per day?					❑< 100 ❑> 100 ❑Unsure
Is your scalp...	❑DRY ❑FLAKING ❑ITCHING ❑GREASY ❑SENSITIVE ❑RED ❑PAINFUL				
Is this the first and only time you have experienced hair loss? - If no, is it like previous times ❑Yes ❑No					❑Yes ❑No
Has your hair started to gray?	❑Yes ❑No	Do you dye your hair?			❑Yes ❑No
Do you wear tight hairstyles?	❑Yes ❑No	Do you use a hot comb?			❑Yes ❑No
Do you notice hair LOSS over other parts of your body? If YES, where?					❑Yes ❑No
Have you been diagnosed with high/abnormal testosterone levels?					❑Yes ❑No
Do you notice excessive hair GROWTH on your (chin, sideburns, chest, nipples, periumbilical)?					❑Yes ❑No
Do you take testosterone supplementation or testosterone replacement therapy?					❑Yes ❑No
Have you seen another doctor for hair loss concerns or for hair restoration options?					❑Yes ❑No
- Was lab testing performed? (If YES, please provide a copy of results)					❑Yes ❑No
- Was a scalp biopsy performed (If YES, please provide a copy of results)					❑Yes ❑No
Are you currently pregnant or breastfeeding?					❑Yes ❑No
Have you experienced Menopause?					❑Yes ❑No

PLEASE INDICATE IF YOU HAVE TAKEN OR ARE CURRENTLY TAKING ANY OF THE BELOW HAIR RESTORATION PRODUCTS (If Applicable)

Name	Yes/No	Strength	How Often	How Long	Hair Regrowth	Side Effects/Comments
Minoxidil- Oral	❑Y/❑N				❑Y/❑N	
Minoxidil- Topical	❑Y/❑N				❑Y/❑N	
Finasteride- Oral	❑Y/❑N				❑Y/❑N	
Finasteride- Topical	❑Y/❑N				❑Y/❑N	
Dutasteride- Oral	❑Y/❑N				❑Y/❑N	
Dutasteride- Topical	❑Y/❑N				❑Y/❑N	
Ketoconazole	❑Y/❑N				❑Y/❑N	
Spironolactone	❑Y/❑N				❑Y/❑N	
PRP (Platelet Rich Plasma)	❑Y/❑N				❑Y/❑N	
Antibiotics-	❑Y/❑N				❑Y/❑N	
Steroids- Oral	❑Y/❑N				❑Y/❑N	
Steroids- Topical	❑Y/❑N				❑Y/❑N	
Steroids- Injection	❑Y/❑N				❑Y/❑N	
Biotin Supplements	❑Y/❑N				❑Y/❑N	
Iron Supplements	❑Y/❑N				❑Y/❑N	
Vitamin D Supplementation	❑Y/❑N				❑Y/❑N	
Nutrafol	❑Y/❑N				❑Y/❑N	
Hims	❑Y/❑N				❑Y/❑N	
Keeps	❑Y/❑N				❑Y/❑N	
Other						

Do you use any shampoos and/or conditioners designed for hair restoration/thinning hair? If so, please list:

Please list all PRESCRIPTION and NON-PRESCRIPTION medications, vitamins/supplements not listed above that you take regularly or occasionally.

Name	Strength, Frequency, Duration	Name	Strength, Frequency, Duration

Meds/OTC/vitamins/supplements continued:

Thank you for your interest in our Hair Restoration Clinic. We look forward to meeting you!