FLORIDA ROBOTIC
HAIR TRANSPLANT CENTER

Medical History Form

Last Name: _____ First Name: _____ Middle Name:_____

Date of Birth:_____ Phone: _____ Email Address:_____

Home Address: _____ Employer:_____

Emergency Contact Name:_____ Phone:_____

Do you have a history of: (Please place an "X" in the Yes or No box that correctly applies to you)

	Yes	No
Bleeding problems (nose bleeds, gum bleeds, easy bruising, etc.)		
Poor or abnormal healing (wide scars, raised scars, larger scars, keloids, slow healing)		
Liver problems (Hepatitis)		
High blood pressure		
Heart disease (heart attack, arrhythmia, irregular pulses, heart murmur, etc.)		
Lung disease (asthma, pneumonia, chronic bronchitis)		
Hormonal diseases (Diabetes, Thyroid problems, etc.)		
Kidney/Bladder disease (prostate)		
Stomach disease (ulcers, heartburn, etc.)		
Neurologic disease (stroke, seizure, fainting)		
Hay fever, Hives, Eczema		
Do you have any artificial joints, artificial heart valves, or metal pins?		
Glaucoma		
Disorders of the immune system		
Tattoos		
Blood transfusions		
Emotional problems (depression, anxiety, panic disorder, etc.)		
Have you been told you need antibiotics PRIOR to surgery?		
Rare disorders (Hereditary Angioedema, Malignant Hyperthermia)		
Are you harder to “freeze” or “numb” with local anesthetics than most people?		

Weekly cigarette use: _____ List any smoking history:_____

Weekly alcohol intake: _____ List any other drug use: _____

What (if any) treatments have you tried for your hair loss (including topicals, oral and procedures, etc.). _____

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Are you allergic to or have had a "bad reaction" to any of the following local anesthetics occasionally used in surgery? (Please circle)

Novocain - Xylocaine - Skin Tape - Iodine - Valium - Penicillin - Codeine - Prednisone - Substances applied to skin

List any other medications to which you are allergic to or have had a "bad reaction" to:

List all prescription or non-prescription medications, drugs, vitamins, or nutritional supplements you take either regularly or occasionally: (Including Rogaine, Vitamin E, over-the counter pain and arthritis medications like Advil or Motrin, etc.)

Please list any operations, or serious medical illness not mentioned above or give details of questions answered yes above:

How did you hear about us: _____

Primary Physician Information:

Name: _____ Number: _____

Address: _____

_____

Signature **Date**