SHAPIRO MEDICAL GROUP

ADVANCED HAIR RESTORATION

MEDICAL HISTORY

Last Name: _____ **First Name:** _____ **Date:** ____/____/_____

DO YOU HAVE A HISTORY OF: (Please circle "Y" or "N")

• **Bleeding Problems (nose bleeds, gum bleeds, easy bruising, etc.)**	**Y**	**N**
• **Poor or Abnormal Healing (wide scars, raised scars, larger scars, keloids, slow healing)**	**Y**	**N**
• **HIV-Positive (confidential, but needs to be known to protect patient and staff)**	**Y**	**N**
• **Blood Transfusions**	**Y**	**N**
• **Liver Problems (hepatitis)**	**Y**	**N**
• **Diabetes**	**Y**	**N**
• **High Blood Pressure**	**Y**	**N**
• **Heart Disease (heart attack, arrhythmia, or irregular pulse, heart murmur, etc.)**	**Y**	**N**
• **Lung Disease (asthma, pneumonia, chronic bronchitis)**	**Y**	**N**
• **Kidney / Bladder (prostate, disease)**	**Y**	**N**
• **Stomach Disease (ulcers, heartburn, etc.)**	**Y**	**N**
• **Neurolgic Disease (stroke, seizure, fainting)**	**Y**	**N**
• **Do you have any artificial joints, artificial heart valves, metal pins, etc. in the body?**	**Y**	**N**
• **Emotional problems (depression, anxiety, panic disorder, etc.)**	**Y**	**N**
• **Glaucoma**	**Y**	**N**
• **Have you been told you need antibiotics PRIOR to surgery**	**Y**	**N**

Please explain in detail to answers of "yes" above: _____

Average weekly alcohol intake: _____ **Average weekly cigarette use:** _____

Are you allergic to any of the following medications which are occasionally used in surgery:

(Please circle) Novocain - Xyolocian - Skin Tape - Iodine - Valium - Penicillin - Codeine - Prednisone

List any other medications to which you are allergic: _____

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

Please list any operations, hospitalizations or medical illness not mentioned above: