CENTER FOR HAIR TRANSPLANTATION

Ivan S. Cohen, M.D.

HAIR TRANSPLANTATION CONSULTATION

Patient name: _____ Date: _____

E-mail address: _____

1. How long have you been losing your hair? _____

2. Have you had a previous hair transplantation? _____

3. Have you ever worn a hairpiece? _____

4. Are you taking any medications for hair loss? If yes, please list them.

_____

5. Are you taking any blood thinners or aspirin? If yes, please list them.

_____

6. Are you allergic to, or have you had any bad reactions to any drugs/medications? If yes, please list them.
No _____ Yes _____

7. Are you allergic to, or have you had any bad reactions to local anesthetics (dentist)? If yes, please list them.
No _____ Yes _____

8. Have you had any allergic reactions to any substance applied to your skin? If yes, please list them.
No _____ Yes _____

9. Do you require more anesthetic at the dentist than most people? No _____ Yes _____

10. Do cuts on your skin ever heal with abnormal scars (KELOIDS)? No _____ Yes _____

HAIR LOSS HISTORY IN FAMILY

1. Father or fathers' family? No _____ Yes _____

2. Mother or mother's family? No _____ Yes _____

3. Brother(s) or sister(s)? No _____ Yes _____

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