John Kiely, M.D., Chartered

Name: _____ **Date:**_____

Date of Birth: _____ **Age**: _____ **Marital Status**: _____ **Sex: M ___ F ___**

Do you have or have you ever had any of the following? (Please check yes or no.)

	Yes	No		Yes	No		Yes	No
Psychiatric Disorder	___	___	Kidney Disease	___	___	Diabetes	___	___
Thyroid Disorder	___	___	Ulcer Disease	___	___	Cancer	___	___
Rheumatic Fever	___	___	Epilepsy	___	___	Jaundice	___	___
Heart Disease	___	___	Arthritis	___	___	Hepatitis	___	___
Liver Disease	___	___	Tuberculosis	___	___	Asthma	___	___
High Blood Pressure	___	___	Heart Murmur	___	___	HIV	___	___
Migraine Headaches	___	___	Infections/Fever	___	___	Polio	___	___
Menstrual Disorder	___	___	Chest Pain	___	___	Anemia	___	___

Do you smoke? _____ If so, how much? _____

Is there any history of substance abuse? _____

Do you have any bleeding disorders? _____

Are you allergic to any medications? _____ If so, please list. _____

Are you taking any of the following? Please circle:

Anti-Cholesterol Agents Beta Blockers Oral Contraceptives Vitamins Prozac

Lithium Ace Inhibitors How long? _____

Are you taking any other medications not listed above at this time? _____

List any other medications you have taken recently, especially aspirin and anticoagulants - how longyou have been taking them and when you have stopped. _____

Have you had any surgeries? _____

Have you had difficulty healing, unusual scarring or keloid formation? _____

Have you ever had general anesthesia? _____

Is there any other medical information not covered by this questionnaire? _____

With regards to hair loss, list date of onset and explain. _____

Family History:

Does any member of your family have or did they ever have any of the following? Please circle.

Diabetes Thyroid Disease Cystic Ovary Disease Hair Loss

Explain. _____

Complications Covered: Bleeding _____ Swelling _____ Infection _____

Number of Needed Procedures Covered _____ (always requires two or more procedures)

PHYSICAL EXAM

BP _____ Pulse _____ Chest _____ Heart _____

Skin Appearance _____ Scalp _____ Donor _____

Pull Test _____ Hair Shaft and Follicle Appearance _____

Notes: _____

John A. Kiely, M.D. _____ Patient Signature: _____