



DOCUMENTS FOR
CONSULTATION

Personal information

Surname and name

.....

Sex

M

F

X

Language(s)

Dutch

French

German

English

Italian

Spanish

Other:

Street & number

Zip code & city

.....

Country

Date of birth

.....

Mobile number

Email

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How did you get to know Dr. Feriduni Hair Clinic?

Internet

Online forum

Word-to-mouth

Hairdresser

Other:

Medical information

Do you suffer from any allergies or sensitivities? No Yes

If yes, which one(s)?

- Jewelry Make-up Medication Dust/pollen
 Food or drinks Local anesthesia Other

Do you suffer from high blood pressure? No Yes

- Often bleeding nose Quick bruises Haemophilia

Do you suffer from any blood diseases? No Yes

If yes, which one(s)?

Do you suffer from anemia? No Yes

Do you suffer from iron deficiency? No Yes

Do you suffer from diabetes? No Yes

Do you risk infections caused by rheumatism, your heart or kidneys?

- No Yes

Do you suffer from any heart problems? No Yes

Did you ever had a heart attack? No Yes

If yes, when exactly was this?

Do you have problems with your blood circulation? No Yes

Do you have blood pressure problems? No High Low

Do you have an infection disease? No Yes

If yes, which one(s)?

- TBC Hepatitis AIDS Other:

Do you have asthma or respiratory problems? No Yes

If yes, which one(s)?

Do you have hormonal disfunctions? No Yes
If yes, which one(s)?

Were you ever refused to donate blood? No Yes
If yes, why?

Do you find trouble with wound healing? No Yes

Slower healing process Suppuration Abscesses
 Fistula Bad healing or scars

Do you often take medication? No Yes

Medication for the heart Painkillers (Aspirin)
 Anticoagulants (Marcumar) Other

Were you the last 12 months in a doctor's treatment? No Yes
If yes, why?

Do you drink alcohol? No Yes
If yes, how much and how often?

Do you smoke? No Yes
If yes, how much and how often?

Do you take drugs? No Yes
If yes, what, how much and how often?

Would you like to share anything else that's medically relevant for us?
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Hair loss (if applicable)

From what age did you start losing hair?

I don't suffer from hair loss I don't know

15-19 20-24 25-29 30-34 35-39 40+

How fast are you losing hair?

Slowly Average Fast Very fast

I don't know I don't suffer from hair loss

Are you using medication with Finasteride (e.g. Propecia)?

No, never have

Not any more since..... Reason

Yes, since Dosage

Are you using medication with Dutasteride?

No, never have

Not any more since..... Reason

Yes, since Dosage

Are you using medication with Minoxidil (e.g. Regaine)?

No, never have

Not any more since..... Reason

Yes, since Dosage

Are you using other medication against hair loss?

No, never have

Not any more since..... Reason

Yes, since Dosage

Name of the medication:

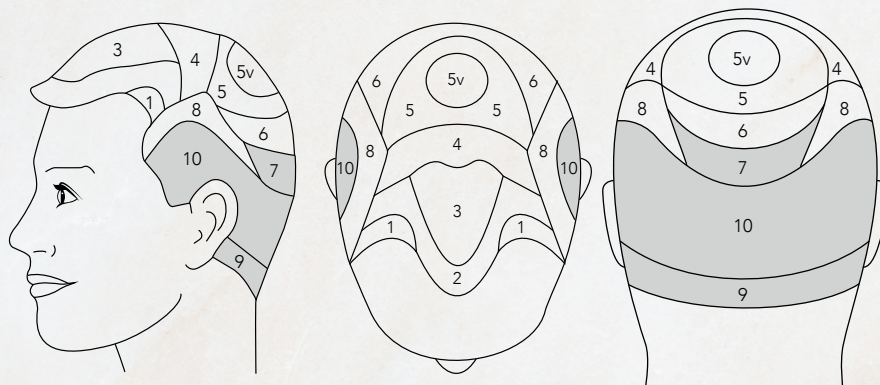
Do you follow any other treatments or are you using hair thickening products?

Micropigmentation Hair thickening spray or Toppik Other

Earlier treatments

	Year	Technique	Grafts	Doctor or clinic
1
2
3
4

Family history



Please fill in the affected areas

Father's side:

Mother's side:

Brothers:

Father:

Uncle(s):

Brother(s):

Uncle(s):

Grandfather:

Grandfather:

Please explain shortly what you expect from a hair transplantation?

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