Confidential Client Profile

DATE____________________

Name____
Address____
City________________________ State__________ Zip__________
Telephone (home)____________________ (work)______________________
(cell)______________________ Email_______________________
Age________ Date of Birth_____________
Employer_____________________ Occupation___________________________
Marital Status______________ Spouse's First Name_______________________

1) How did you hear about **VSC**? ____TV ____Radio ____ Newspaper ____Internet
____Yellow Pages Referred by____

2) How long ago did you receive our information kit/brochure?______________________

3) How old were you when you first noticed your hair loss?_________________________

4) Please detail any hair loss in other members of your family.______________________
____

5) What other hair replacement alternatives/options have you considered?
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6) What attracted you to VSC?____

7) What concerns do you have about restoring your hair? ___________________________
____

8) What activities do you participate in? (please check) _____ Baseball _____Basketball
_____ Football _____Water Sports _____Tennis _____Weight Lifting _____Running
_____Biking _____Golf Other:______________________________

9) Please indicate the areas in which your hair loss affects you. (please check)
____Meeting new people ____Your self esteem ____Your overall appearance
____On a windy day ____When you dress up ____When others make comments
____At the beach/swimming ____When playing sports ____When having to wear a hat
____In your social life ____Seeing old friends ____At work

Other:____

HEALTH HISTORY

1) Are you generally in good health? Yes No

2) Are you presently under a doctor's care? Yes No

3) Have you had prior hair transplants? Yes No

4) Have you ever been diagnosed with:

a) Heart Disease	Yes	No
b) High Blood Pressure	Yes	No
c) Liver Disease	Yes	No
d) Kidney Disease	Yes	No
e) Lung Disease	Yes	No
f) Fainting Spells	Yes	No
g) Convulsions	Yes	No
h) Venereal Disease	Yes	No
i) Diabetes	Yes	No
j) Dizziness	Yes	No

5) Do you presently have: (please check)

____Hay Fever ____Asthma ____Hives ____Eczema ____Ringworm

6) Have you ever had any type of bleeding disorder (e.g. easy bruising, abnorrmal nosebleeds, profuse bleeding when cut)? Yes No

7) Do cuts on your skin heal normally? Yes No

8) Have you any tendency toward keloids (raised ridged scars)? Yes No

9) Do you require additional anesthesia (ex. Xylocaine, Lidocaine, etc.)? Yes No

10) Have you ever had any allergic reaction to anesthesia? Yes No

11) Do you have any allergic response or adverse reaction to substances placed on your skin? Yes No

12) Do you regularly take abnormal amounts of aspirin? Yes No

13) Do you have any allergic response or adverse reaction to drugs or medications? Yes No

14) Have you ever been treated for drug (Prescription or non prescription) or alcohol abuse? If **Yes** – Please Describe: Yes No

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15) List present drugs and medications taken or prescribed:

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16) List any prior surgeries: ____

Patient Signature ________________________Date____________________________________

Physician Signature____________________

Physicians
Notes:____
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