Concept Chiropractic
+ Regenerative Medicine
Renew Yourself

PATIENT MEDICAL HISTORY AND HAIR LOSS CONSULTATION FORM

PATIENT INFORMATION

Name:	Date of Birth:	Age:	Gender:
Chief Complaint:			

HPI (History of Present Illness):
Please describe general history of your current condition and why you are seeking this consult

PAST MEDICAL HISTORY

Do you have, or have you ever had any of the following? Please check below:

☐ Adrenal Disorder	☐ Alcohol abuse	☐ Alzheimer's Disease and Related Dementia	
☐ Arthritis (Osteoarthritis or Rheumatoid)		☐ Asthma	☐ Atrial Fibrillation
☐ Autism Spectrum Disorder	☐ Autoimmune Disorder	☐ Cancer (Breast, Colorectal, Lung, Prostate, Other)	
☐ Chronic Kidney Disease	☐ Chronic Obstructive Pulmonary Disease		☐ Depression
☐ Diabetes I	☐ Diabetes II	☐ Drug Abuse/ Substance Abuse	
☐ Heart Failure	☐ Hepatitis (Chronic Viral B & C)		☐ HIV/AIDS
☐ Hyperlipidemia (High Cholesterol)		☐ Hypertension (High Blood Pressure)	
☐ Ischemic Heart Disease	☐ Liver Disease, Osteopenia/Osteoporosis		☐ Skin Disorder
☐ Schizophrenia or Other Psychotic disorder		☐ Stroke	☐ Thyroid Condition
☐ Other:			

Do you have, or have you ever had any of the following skin conditions?

☐ Acne	☐ Atopic Dermatitis (Eczema)	☐ Basal Cell Carcinoma	☐ Cellulitis
☐ Rosacea	☐ Psoriasis	☐ Vitiligo	☐ Alopecia
☐ Dry Skin	☐ Folliculitis	☐ Hyperhidrosis	☐ Hyperpigmentation
☐ Chronic Kidney Disease	☐ Chronic Obstructive Pulmonary Disease		☐ Depression
☐ Lupus	☐ Melanoma	☐ Shingles	☐ Squamous Cell Carcinoma
☐ Urticaria (Hives)	☐ Other:		

Do you have any other health conditions currently being treated by your PCP or specialist?

Surgeries/Hospitalizations:

Pertinent Family History (Hair Loss, Skin/Autoimmune Disorders, Etc.):

SOCIAL HISTORY

Occupation:	Alcohol (Freq):
Exercise (Freq):	Tobacco (Freq):

Allergies:

☐ Medications ☐ Food ☐ Latex ☐ Sulfa Antibiotics ☐ Other Substances ☐ please include reaction:

REVIEW OF SYSTEMS

GEN:

☐ Weight Loss ☐ Pain ☐ Fatigue ☐ Fever or Chills ☐ Changes in Sleep ☐ Other:

HEENT:

☐ Headache ☐ Hearing Change ☐ Vision Change ☐ Vertigo ☐ Congestion
☐ Rhinorrhea (Runny Nose) ☐ Sore Throat ☐ Swelling of Neck ☐ Other:

RESP:

☐ Cough/Sputum ☐ Shortness of Breath ☐ Wheezing ☐ Other:

CV:

- [ ] Chest Pain or Pressure
- [ ] Arrythmia or Palpitations
- [ ] Shortness of Breath
- [ ] Lower Extremity Swelling
- [ ] Pain/Cramping in Legs
- [ ] Other:

GI:

- [ ] Nausea/Vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Appetite Change
- [ ] Heartburn
- [ ] Abdominal Pain
- [ ] Bloody Stool
- [ ] Other:

GU/Urinary:

- [ ] Frequent Urination
- [ ] Urgency
- [ ] Pain/Burning
- [ ] Hematuria (Blood in Urine)
- [ ] Itching/Rash
- [ ] Irregular Menses
- [ ] Other:

MSK:

- [ ] Muscle or Joint Pain/ Stiffness
- [ ] Back Pain
- [ ] Swelling of Joints
- [ ] Restricted Motion
- [ ] Muscle Cramps
- [ ] Other:

SKIN:

- [ ] Rashes
- [ ] Lesions
- [ ] Sores
- [ ] Blisters
- [ ] Growths
- [ ] Itching
- [ ] Other:

ENDO:

- [ ] Hot/Cold Intolerance
- [ ] Sweating
- [ ] Excess Urination
- [ ] Excess Thirst
- [ ] Other:

NEURO:

- [ ] Numbness
- [ ] Tingling
- [ ] Sensation Loss
- [ ] Burning
- [ ] Loss of Balance
- [ ] Lightheadedness
- [ ] Dizziness
- [ ] Other:

PSYCH:

☐ Nervousness ☐ Anxiety ☐ Depression ☐ Memory Loss ☐ Other:

HEME/LYMPH:

☐ Abnormal Bleeding ☐ Swelling ☐ Other:

ALL/IMMUN:

☐ Rashes ☐ Itching ☐ Recurrent Infections ☐ Other:

FOR WOMEN ONLY

Are you pregnant or breastfeeding? ☐ Yes ☐ No

Are you planning on being pregnant or breastfeeding? ☐ Yes ☐ No

Are your menstrual periods regular? ☐ Yes ☐ No

Have you ever been diagnosed with PCOS? ☐ Yes ☐ No

LABS

Please provide any recent lab work available from PCP Labs That Are Beneficial Prior to Appointment (Able to be Ordered in Office): CBC, CMP, CRP, B12, Iron Panel, Thyroid panel (TSH, T3/T4), Estradiol, Total and Free Testosterone, Vitamin D, or any additional labs pertinent to your current health condition

IMAGING

Please provide any recent imaging available from PCP

VACCINATION

Have you recently had the Covid- 19 vaccine or booster in the past 90 days? ☐ Yes ☐ No

MEDICATIONS

Do you take ANY medications (prescriptions or non-prescriptions) including vitamins, herbal supplements, blood thinners, oral steroids? ☐ Yes ☐ No If yes, please list.

Do you take any topical products (medical or non-medical) that you use on your skin daily? ☐ Yes ☐ No
If yes, please list.

HAIR

Have you had any cosmetic procedures in the past month? ☐ Yes ☐ No If yes, please list.

When did you start to notice your hair thinning / loss?

What areas of concern bother you most?

What do you hope to get out of this treatment?

Have you tried any other treatments for hair thinning / loss? ☐ Yes ☐ No If yes, please list.

Would you say your hair is affecting your confidence or self-esteem? ☐ Yes ☐ No

Have you ever worked in hazardous conditions that may have affected your hair or skin? ☐ Yes ☐ No
If yes, please list.