HAIR RESTORATION
BERGMANN KORD
MEDICAL CLINICS

MEDICAL HISTORY

Hair Transplantation

Surname: .... Name: ....

Age: .... Date: .... / .... / ....

Do suffer from a chronic disease?

YES ☐ NO ☐

If yes, what is it? ....

What medication are you taking to deal with it? ....

....

Do you have any heart disease?

YES ☐ NO ☐

If yes, what is your problem?...

What medication are you taking to deal with it? ....

....

Do you suffer from a blood coagulation disorder?

YES ☐ NO ☐

If yes, what is it? ....

....

What medication are you taking to deal with it and when did you stop taking them? ....

....

Have you ever been hospitalized, for any reason, over the last five years?

YES ☐ NO ☐

If yes, when did this happen and for what reason? ....

....

Have you been subjected to any type of surgery over the last five years?

YES ☐ NO ☐

If yes, what kind of surgery was it, when did it happen, what kind of anesthesia was used
and what was the outcome? ....

....

Are you currently taking any medication, systematically or occasionally, for any reason?

YES ☐ NO ☐

If yes, what is the medication and for what reason and for how long have you been taking it? ....

....

Have you ever had any side effects from using medication? YES ☐ NO ☐

If yes, what medication was involved and what were the side effects? ....

....

Are you allergic to any medication, food or other substances? YES ☐ NO ☐

(Mainly, referring to allergies, local anesthetics and antibiotics).

If yes, to what substance and what was the form of the allergy? ....

....

Are you practicing any gymnastic or athletic activity? YES ☐ NO ☐

If yes, how often do you exercise and how? ....

....

Have you ever had an incident like fainting during exercise? YES ☐ NO ☐

If yes, how often do you exercise and how? ....

....

Have you undergone a cardiological check during the last year? YES ☐ NO ☐

If yes, for what reason, which tests were included and what were the results? ....

....

Have you taken a blood test during the last year? YES ☐ NO ☐

If yes, what was the reason, which tests were included and what were the results? ....

....

Have you been subjected to any other clinical cross-check during the last year? YES ☐ NO ☐

If yes, what was the reason, which tests were included and what were the results? ....

....

Do you take vitamins or dietary supplements? YES ☐ NO ☐

If yes, what are they and when did you stop taking them? ....

....

I declare that I have answered honestly the Medical History questionnaire, without having concealed any information about my health condition. I have also been fully informed about the operation I am about to undergo, the post-operative development at every stage, and I am consciously approving its implementation.

Doctor's Signature **Patient's Signature**

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