# Hair Transplant Intake

## MEDICAL HISTORY QUESTIONNAIRE

Title *

- ◯ Mr
- ◯ Mrs
- ◯ Ms
- ◯ Miss
- ◯ Dr
- ◯ Other

**If other, please state:** _____

Pronouns:

◯ He/Him ◯ She/Her ◯ They/Them ◯ No Preference

**Patient First Name: *:** _____ **Patient Last Name: *:** _____

**D.O.B: *:** _____ dd / mm / yyyy **Weight (kg): *:** _____

**Height (cm): *:** _____ **Address: *:** _____

**Postcode: *:** _____ **Contact Number: *:** _____

**Email: *:** _____ **Occupation: *:** _____

**Emergency Contact Name: *:** _____ **Emergency Contact Relationship *:** _____

**Emergency Contact Phone Number *:** _____

## PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE:

Do you have or have you suffered from any of the following:

Heart Complaints e.g., heart attack, angina, surgery, AF, Pacemaker *

◯ No ◯ Yes

Rheumatic fever *

◯ No ◯ Yes

Diabetes *

◯ No ◯ Yes

Thyroid Disease *

◯ No ◯ Yes

Chronic bronchitis, asthma, previous TB or respiratory illness *

◯ No ◯ Yes

Do you have any auto-immune conditions (Ulcerative colitis, Crohn's disease, Rheumatoid arthritis etc.) *

◯ No ◯ Yes

Epilepsy, fainting episodes or neuro-surgery *

◯ No ◯ Yes

Depression/Anxiety or any psychiatric illness *

◯ No ◯ Yes

Excessive bleeding or easily bruised *

◯ No ◯ Yes

Reaction to local anaesthetic *

◯ No ◯ Yes

High/Low blood pressure *

◯ No ◯ Yes

Are you or could you be pregnant at present *

◯ No ◯ Yes

Have you been treated with hydrocortisone or cortico-steroids *

◯ No ◯ Yes

Do you carry a medical warning card *

◯ No ◯ Yes

In the past have you had any surgeries *

◯ No ◯ Yes

Do you have any allergies to medicines or anything else *

◯ No ◯ Yes

Have you ever been diagnosed with Hepatitis *

◯ No ◯ Yes

Have you ever been investigated for any blood borne or infectious diseases *

◯ No ◯ Yes

Are you HIV positive *

◯ No ◯ Yes

Any dermatological skin or scalp conditions such as Eczema/ Psoriasis/Alopecia *

◯ No ◯ Yes

Any history of burns or scars (keloid scars) *

◯ No ◯ Yes

Any recent injuries/accidents (fracture or muscular injuries) *

◯ No ◯ Yes

Any previous hair loss treatment (inc. medication such as Finasteride, Minoxidil, PRP, laser etc.) or hair transplant surgery *

◯ No ◯ Yes

If yes to above, have you experienced any side effects with the medication such as sexual dysfunction, anxiety and low mood *

◯ No ◯ Yes

Are you seeking hair restoration treatment to improve your self-esteem and confidence *

◯ No ◯ Yes

Any other illness not mentioned above (physical or psychological) *

◯ No ◯ Yes

**If you answered "Yes" to any of the above, please explain in detail:**

**Are you at present taking any medication? If yes, please state name and dose:**

Do you smoke?

◯ No ◯ Yes

**If yes how many per day:** _____

Do you drink alcohol?

◯ No ◯ Yes

**If yes, how many units per week?:** _____ **Name of your GP: *:** _____

**GP Surgery Name *:** _____

**GP Surgery Address ***

**How did you hear about us? *:** _____

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**Patient Signature ***

**Date of Signature *:** _____ dd / mm / yyyy

Official Identification Request: Why We Ask for Identification – Your Safety Comes First At KSL Clinic, our priority is your safety and the quality of care you receive. As part of our commitment to maintaining high standards, we kindly ask all patients to upload a valid form of identification before undergoing any surgical or non-surgical hair transplant procedures. This step is part of our compliance with the Care Quality Commission (CQC) and is required for two important reasons: To Protect Your Safety: Verifying your identity helps us ensure that all medical records, consultations, and treatments are correctly matched to you, reducing the risk of errors and ensuring continuity of care. To Meet Regulatory Standards: The CQC requires all registered healthcare providers to confirm patient identity, which supports the safe and professional delivery of medical treatments. Please be assured that your information will be handled securely and in strict confidence, in accordance with data protection laws and KSL Clinic's privacy policy.

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If you have any questions about the above please discuss these with your practitioner.

If the answer is yes to any of the above, your practitioner may ask for further details.

Please keep your doctor informed of any changes to your health.