CONFIDENTIAL CONSULTATION QUESTIONNAIRE

Name: ___________________________________Date: ______________________

Address: ____

City: ____________________State___________________Zip____________________

Home Phone_______________________Work phone___________________________

DOB__________________ Age_________Occupation__________________________

E-mail Address____

Referred by: Doctor _____Google ___ Social Media_______ Client referral _____________
Other_________________

Primary Care doctor____

Medical History
Allergies______________________ (shellfish)

Previous Surgery with General Anesthesia______________________________________

Have you had covid 19 in the last 6months? ____________________________________

Current Medial Conditons____

Presently Undergoing Medical Treatment for_____________________________________

Are you under the care of a Dermatologist? ____________________Name_______________

Medications: Please list name of medication and dosage including vitamins and over the counter meds.____

Any know scalp disorders or issues the Trichologist should be aware of?
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Reason for consultation ____