MARK A. BISHARA M.D.
Cosmetic Surgery & Hair Restoration

Name:_____ Home Phone:_____ Occupation: _____

Address: _____

What 2 movies have you not seen but would like too? _____

Health Insurance Policy number: _____ Group number:_____
Hair-loss History:

At what age did you first notice hair loss? _____ What family members also have hair loss?_____

What products of treatments have you used to try to improve you hair? _____

What concerns you most about your hair loss? _____

What concerns, if any, do you have in relation to restoring you hair? _____

What concerns you most about your hair loss? _____

Do you use: Rogaine: Yes / No Propecia: Yes / No

What medications are you currently taking? _____

Are you allergic to any drugs or medications (if so, which?) _____

Have you ever has a SEVERE allergis reaction to anything? _____

Have you ever taken over the counter remedies or supplements for hair loss? _____

Have you discussed your hair loss with your doctor or dermatologist? _____

What surgery have you EVER had in the past? _____

Have you ever had any of the following? (Circle those that apply)

a. heart disease
b. high blood pressure
c. hepatitis
d. ulcer disease
e. diabetes
f. thyroid / endocrine disease
g. iron deficiency anemia

Have you ever had a blood transfusion?_____

Do you have any other chronic health conditions not listed above? _____

Primary Care Doctor: _____

Phone: _____

Hair and Scalp Evaluation:

Grade_____ Density _____ Scalp Thickness _____ Skin Color _____

Hair Color: _____ Curl _____ Texture _____ Vellous Hair_____

Comments:
_____
_____
_____
_____

M.D. Signature _____ Date _____