Vegas Valley Hair Restoration

Welcome to your hair restoration consultation with Dr. Irwin Simon.

Please read each of the following questions and indicate your answers. Once you complete this confidential patient form, please provide it to the front desk.

Contact Information:

First name: ______________________________

Last name: ______________________________

Best telephone: ______________________________

Email address: ______________________________

Street address: ______________________________

City: ______________________________

State/Zip: ______________________________

Country: ______________________________

Age: ________________

Gender: Male Female

How did you hear about our office?

- ☐ Friend ______________________________
- ☐ Hair Loss Website ______________________________
- ☐ Local News Channel ______________________________
- ☐ Other magazine or newspaper article ______________________________
- ☐ Other ______________________________

Starting to thin

Advanced stage of thinning

Overall thinning

Receding hairline

Bald spot forming in crown

Little or no hair on top of the scalp

Itching or flaking scalp

Increased shedding

Missing, damaged or sparse eyebrows

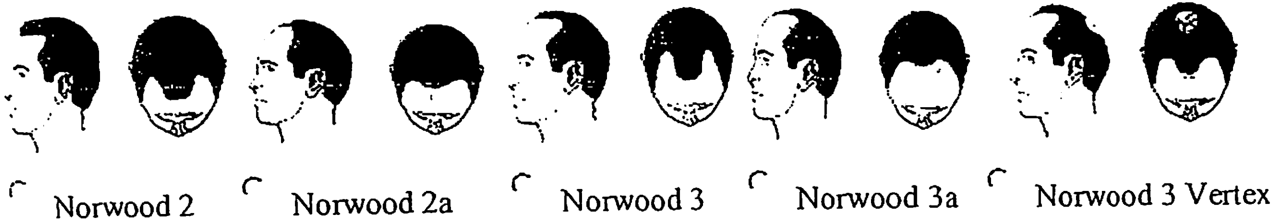
Weak or sparse eyelashes

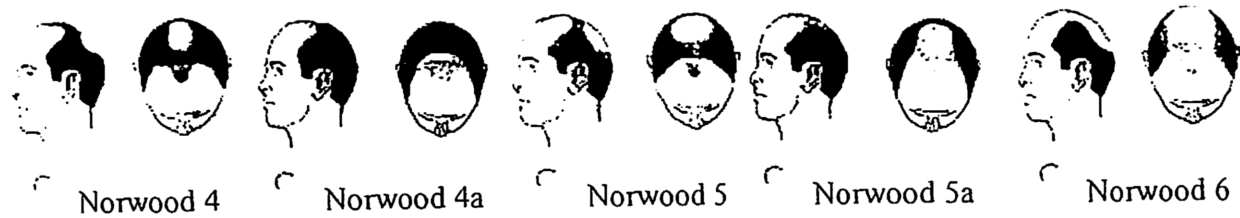
Damaged or traumatized eyelashes

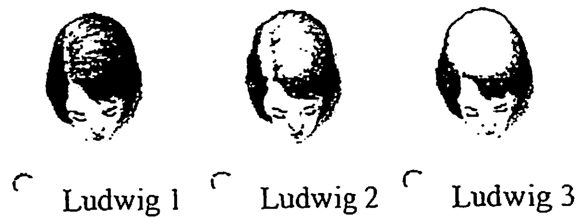
Post-Plastic Surgery Hair Loss

Visible Scar

Please check the box which most closely matches your hair loss pattern.







O Other ____

ig, toupee or weave ☐
air extensions ☐
eative hair styling (comb-over, perms) ☐
owder or spray camouflage ☐

/hat is your family's history of hair loss?

- Mother
- Father
- Maternal grandparents
- Paternal grandparents
- Brother/sister
- Don't know

Your personal hair restoration objectives (check all that apply):

- Hairline restoration
- Increase in frontal density
- Crown coverage
- Stop hair loss / decrease shedding
- Touch-up, refinement or correction of previous procedure
- Scar Coverage
- Other (please explain): ______________________________

Hair restoration solutions of interest:

- NeoGraft FUE Surgical hair restoration (Follicular-unit extraction: FUE/FOX)
- Medical therapy (Propecia, Minoxidil/Rogaine)
- Laser hair therapy (laser hood, laser comb)
- Nutritional supplementation
- Post-Plastic Surgery hair transplantation (describe below)
- Eyelash transplantation
- Eyebrow transplantation
- Beard/moustache transplantation
- Body-hair transplantation
- Scar coverage

- I've started researching my hair restoration options
- I'm interested in starting non-invasive treatment (Propecia, Minoxidil /Rogaine, Laser Therapy)
- I've had a hair transplant before
- I've had a consultation with another doctor
- I'm interested in scheduling a surgical procedure within the next ninety days
- I'm interested in scheduling a surgical procedure within the next year

Patient Comments

Do you have any concerns with the hair the hair transplant procedure? Yes____ No____

If yes, what are they (use the rest of the page for explanation)?

IRWIN B. SIMON, M.D., F.A.C.S.

DATE ____________ ACCT # ____________ NAME ____________

MEDICAL HISTORY

SOCIAL HISTORY

Where were you born? ____________ Age: ______ Height: ______ Weight: ______

Level of Education ____________ Marital Status ____________

Occupation ____________

HABITS

Have you ever smoked or used chewing tobacco? ______ If cigarettes, how many packs a day? ______ How many years? ______ When did you quit? ______

Do you consume alcoholic beverages? ______ Type ______ How much? ______ How often? ______ How many years? ______ When did you quit? ______

Medications: List **ALL** current medications, including over the counter. ____________

____

____

FAMILY HISTORY

Age of father ______ If deceased, age at death ______. Condition of health or cause of death ____________

Age of mother ______ If deceased, age at death ______. Condition of health or cause of death ____________

Number of brothers ______ Condition of health or cause of death ____________

Number of sisters ______ Condition of health or cause of death ____________

Number of children ______ Condition of health or cause of death ____________

FAMILY HEALTH HISTORY

Check the boxes appropriate for you or your family member(s):

	SELF	SIBLING	CHILD	MOTHER	FATHER	GRANDPARENT	OTHER
Cancer: if yes, specify type							
Tuberculosis							
Diabetes							
Hypertension							
Kidney Disease							
Heart Attack or Heart Disease							
Angina							
COPD/Lung Disease							
Rheumatic Fever							

OPERATIONS

List **ALL** your operations in chronological order giving approximate year in which the surgery was performed: ____________

____

____

ALLERGIES / MISCELLANEOUS

Check if you have any of the following: ______ Hay Fever ______ Asthma

______ Food Allergies List ____________

______ Medication Allergies List ____________

Bleeding tendency: ______ Yes ______ No. If yes, please explain ____________

Have you ever taken Cortisone or steroids? ______ Yes ______ No. If yes, when ______. Why? ______

When did you last take them? ____________

OVER

10. Systems review: Check if you **currently have** any of the following:

A. HEENT:

- ☐ Headache
- ☐ Dizziness
- ☐ Convulsions
- ☐ Nervousness
- ☐ Poor hearing
- ☐ Ear infections
- ☐ Ringing in the ears
- ☐ Poor vision
- ☐ Wear glasses
- ☐ Nose bleeds
- ☐ Sinusitis
- ☐ Hoarseness

B. RESPIRATORY:

- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Shortness of breath
- ☐ Cough
- ☐ Spitting up blood
- ☐ Chest pain

C. HEART:

- ☐ Murmur
- ☐ Heart attack
- ☐ Palpitations
- ☐ High blood pressure

D. GASTROINTESTINAL:

- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ Excess gas
- ☐ Bloating after meals
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Peptic ulcer
- ☐ Abdominal pain
- ☐ Hepatitis
- ☐ Liver disease
- ☐ Jaundice
- ☐ Gallbladder disease
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in/on the stools
- ☐ Black tarry stools
- ☐ Hemorrhoids

E. GENITO-URINARY:

- ☐ Kidney infections
- ☐ Bladder infections
- ☐ Urinate at night. If so, how often
- ☐ Kidney stones
- ☐ Blood in urine

F. NEUROMUSCULAR:

- ☐ Rheumatism
- ☐ Arthritis
- ☐ Back trouble
- ☐ Ruptured disc

G. SYSTEMIC:

- ☐ Weight loss. If so, how much ____________
- ☐ Weight gain. If so, how much ____________
- ☐ Anemia
- ☐ Tiredness
- ☐ Weakness

H. MENSTRUAL: (for Women)

Age of onset of menstrual periods ____________

Number of pregnancies ____________ Age at first delivery ____________

Number of miscarriages ____________

Number of stillbirths ____________

When was your last menstrual period ____________

Was it normal ____________ Are your periods regular ____________

Do you have bleeding or spotting between periods ____________

When was your last pelvic and Pap smear ____________

Irwin B. Simon, M.D., F.A.C.S.

Who referred you to Dr. Simon? ______________________________

PATIENT: This section refers to the PATIENT ONLY.

Name ______________________________ Sex _____ Age _____ Birth Date ____________________

Address ______________________________ Home Phone ____________________

City ____________________ State _____ Zip _________ SS# ____________________

Cell Phone ____________________ Email: ____________________

Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Employer ______________________________ Occupation ____________________

Work Address ______________________________ Work Phone ( ) ____________ Ext _____

City ______________________________ State _________ Zip ____________

SPOUSE/PARENT INFORMATION:

Name ______________________________ Relation to Patient____________________

Address ______________________________ Home Phone ____________________

City ____________________ State _______ Zip _________ SS# ____________________

Cell Phone____________________ Birth Date _____________

Employer ______________________________ Occupation ____________________

Work Address ______________________________ Work Phone ( ) ____________ Ext _____

City ____________________ State _______ Zip ________

INSURANCE:

Primary Insurance: ____________________ **Secondary Insurance:** ____________________
ID#: ____________________**Group #** __________ **ID#:** ____________________**Group #**__________
Name of Insured: ____________________ **Name of Insured:** ____________________
DOB for Insured: ____________________ **DOB for Insured:** ____________________

PERSONAL GUARANTEE: I hereby guarantee payment of all charges incurred by me during the course of my examination, surgery or other treatment by Dr. Irwin B. Simon and/or his associates. I agree to pay all co-pays, percentages and/or deductibles that are deemed patient liability by my insurance carrier. Should my account fall into default, I agree to be responsible for any and all collection fees. _______ Initial

INSURANCE DISCLOSURE: I affirm that I have properly listed my Primary Insurance and any Secondary Insurance. I understand that failure to do so may result in denial of payment y the insurance carrier(s). Should this occur, I affirm that I am personally responsible for all charges as noted above under my personal guarantee of payment. _____ Initial

DISCLOSURE AFFIDAVIT: I certify that the information given by me above is correct and complete as I know it. I have supplied the office staff with my current insurance cards and a picture identification card to be copied and kept as part of my record with this office. ________ Initial

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Irwin B. Simon, M.D. and/or his associates to release any information acquired in the course of my examination, surgery, or other treatment to insurance companies or other medical professionals as deemed appropriate by Dr. Simon and/or his associates. I authorize payment of medical benefits directly to Dr. Simon. _______ Initial

Signature (Patient, or parent, if minor) ______________________________ Date ______________