The Institute of Trichologists
10 Harley Street, London, W1G 9PF
admin@trichologists.org.uk
www.trichologists.org.uk

BEST PRACTICE GUIDES: CONSULTATION RESOURCES

MEDICAL HEALTH QUESTIONNAIRE

Please find an example patient medical health questionnaire on pages 2, 3 and 4 of this document.

Name: _____ Date:_____

Address: _____

_____

Mobile: _____ Email:_____

Are you 18 years or over Yes/ No

Medications taken in the last 6 months:_____ _____

_____

Have you experience any of the following?

Difficulty with breathing or rapid heartbeat?

Have you had chemotherapy or radiation therapy in the last year?

Are you presently pregnant (contraindicated)

Are you presently breast feeding (48hrs express milk post procedure)

MRI scan for the head scheduled in the next 6 weeks?

Micropigmentation on the scalp recently or scheduled for the future?

Please mark with a cross where appropriate if any of the following apply:

Cosmetic Allergies	Inflammatory Skin Condition
Undiagnosed lumps or pain in scalp	Blood thinners or Anti-Coagulants
Cuts or abrasions on scalp	Bruise Easily With Minor Injury
Spray Tan	Sunburn
Scar Easily With Minor Injury	Keloid Scar With Minor Injury
Skin Heals Dark With Minor Injury	Accutane Within 6 Months
Steroids Within 6 Months	Heart Condition
Rheumatic Fever	Haemophilia
High Blood Pressure	Epilepsy In Last 3 Years
Seizures in last 3 years	Kidney Disease
Cancer With In Last Year or chemo/radiation	Leukaemia
Vitiligo that has moved in last year	
Auto Immune Conditions- exceptions to alopecia/thyriodism	
Scleroderma (Diagnosed)	Stomach Ulcers (Present)
Cataract	Trichollomania
Nervous / Psychotic Conditions	Impetigo
Low Blood Pressure	Recent stroke
Liver Disease	Asthma
Tumours, Growths Or Cysts	Diabetes – insulin dependant
HIV	Systemic Lupus Erythematosus
Shingles	Tuberculosis (Present)
Glaucoma	Watery Eyes
Eye infections regular or present	Alopecia
Recent Hair Loss	Contagious Disease (Present)
Fever (Present)	Sun Beds And Tanning Regularly
Botox In Last 2 Weeks	Laser / IPL close to scalp/face
Chemical Peel In Last 6 Months	Dermabrasion Last 6 Months
AHA Skin preparations	Retina A
Vomiting / Diarrhoea	

Do you have a condition presently under supervision of a doctor or dermatologist? If yes, please provide details if none of the above applies.

Warnings and precautions

Please always use _____ exactly as instructed on the information leaflet. If you suffer any adverse reaction such as chest pain, increased heart rate, faintness or dizziness, sudden and unexplainable weight gain, swollen hands or feet, persistent reddening or irritation of the scalp, then stop using _____immediately.

Seek medical attention from your doctor and/or a pharmacist and contact _____.

Patient
Name.....Signature.....