TAMPA BAY HAIR RESTORATION
MARKOU MEDICAL

1266 Turner St
Clearwater, FL 33756
Ph # 727.446.0176
Fax # 727.442.0696

Date: Please Print

PATIENT INFORMATION

Patient's last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. Marital status (circle one) Single / Mar / Div / Sep / Wid

Email: Driver's License No. Social Security no. Birth date: / / Age: Sex: ❑ M ❑ F

Street address: Cell phone no: Home phone no: ( )

P.O. box: City: State: ZIP Code:

Occupation: Employer: Work ph#

Referred to clinic by (please check one box): ❑ Dr. ❑ Radio ❑ Internet

❑ Family ❑ Friend ❑ TV ❑ Other

Person who referred you/Other:

Best way to be contacted

Phone [ ] Text [ ] Email [ ]

General Permission to Treat

The undersigned here by gives permission for Dr.Markou, and any licensed staff member to diagnose and treat their medical problems.

Sign _____ Date _____

Drug Allergies:

_____

_____

_____

_____

_____

Current Medications:

_____

_____

_____

_____

_____

Family History: (Please select any that apply to immediate family)

Heart Disease [ ] High Blood Pressure [ ] Stroke [ ] Cancer [ ] Glaucoma [ ] Diabetes [ ] Epilepsy/Convulsions [ ]

Bleeding Disorder [ ] Kidney Disease [ ] Thyroid disease [ ] Mental illness [ ] Osteoporosis [ ]

Medical History:

Heart palpitations [ ] Asthma [ ] GI disorder [ ] Depression [ ] Prostate Cancer [ ] Sexual/Menstrual Dysfunction [ ]

Hepatitis [ ] Anemia [ ] Thyroid Disease [ ] HIV infection [ ] Bleeding Disorder [ ] Mental Illness [ ] Cancer [ ]

High Blood Pressure [ ] Diabetes [ ]

Other:

_____

_____

_____

_____

Habits:

Smoke [ ]No [ ]Yes if Yes, how many daily:

_____

For how long: _____

Marijuana [ ]No [ ]Yes if Yes, how often: _____

Alcohol [ ]No [ ]Yes if Yes, type: _____

Amount _____

Exercise [ ]No [ ]Yes if Yes, describe: _____

Caffeine [ ]No [ ]Yes [ ]Coffee [ ]Tea [ ]Other

_____

Hospitalization or Surgery:

_____

_____

_____

_____

Have you been to another consultation with another hair transplant physician prior to visiting Dr.Markou?

Yes [ ] No [ ]

What options have you discussed?

_____

_____

_____

_____

Have you had any previous hair restoration procedure(s)? Yes [ ] No [ ]

If Yes, please list the Doctor's name, clinic and date of procedure:

_____

_____

Please select any other treatments that you had prior or currently utilizing:

Propecia (finasteride) [ ] Rogaine (Minoxidil) 2% [ ] or [ ] 5% Low Level Laser Treatment (LLL) [ ]

Platelet Rich Plasma (PRP) [ ] Other Non-Surgical Treatments:

_____

When was your last physical and lab with your family physician?

_____

_____

Have you had any local anesthesia issues? (difficult to numb at dentist office):

Yes [ ] No [ ]

If Yes, please explain:

_____

_____

_____

_____

How soon are you considering to have your procedure?

1 week or more [ ] 1 month or more [ ] Not sure [ ]

Are you considering FUE (ARTAS), FUT (Strip)?

FUE [ ] FUT [ ]

What area(s) are you interested in restoring?

Frontal [ ] Mid [ ] Crown/Vertex [ ]

Do you form large scars when healing, ie keloids?

Yes [ ] No [ ]

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): Relationship to patient: Home phone no.: ( ) Work phone no.: ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize **Tampa Bay Hair Restoration** to release any information required to process my claims.

Patient/Guardian signature *Date*

TAMPA BAY HAIR RESTORATION-MARKOU MEDICAL

Receipt of Notice of Privacy Practices Written Acknowledgement Form

I, _____ have received a copy of

Tampa Bay Hair Restoration-Markou Medical notice of privacy practices.

Patients Signature: _____

Date: _____