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PATIENT NAME: \_\_\_\_\_ D.O.B \_\_\_\_\_ DATE: \_\_\_\_\_

**PATIENT HISTORY**

**PLEASE FILL OUT AND RETURN TO AGE DEFYING SURGICAL CENTER 1 WEEK PRIOR TO PROCEDURE IF POSSIBLE.**

1. Do you have any allergies to any medications, and if so, which? YES \_\_\_\_\_ NO \_\_\_\_\_
2. Are you allergic to any of the following:
 

<b>Xylocaine</b>	YES	NO	<b>Latex</b>	YES	NO
<b>Epinephrine</b>	YES	NO	<b>Iodine</b>	YES	NO
<b>Marcaine</b>	YES	NO	<b>Valium</b>	YES	NO
<b>Acetaminophen</b>	YES	NO	<b>Versed</b>	YES	NO
<b>Codeine</b>	YES	NO	<b>Kenalog</b>	YES	NO
<b>Hydrocodone</b>	YES	NO	<b>Keflex</b>	YES	NO
3. Are you currently taking any medications prescribed by a doctor for any condition whatsoever, and if so, what?  
 NO \_\_\_\_\_ YES \_\_\_\_\_
4. Do you take any over-the-counter drugs on a regular basis, and if so what?  
 NO \_\_\_\_\_ YES \_\_\_\_\_
5. Do you have any source of chronic infection (eg. Chronic osteomyelitis), and if so, what?  
 NO \_\_\_\_\_ YES \_\_\_\_\_
6. Do you have any problems with your immune system? NO \_\_\_\_\_ YES \_\_\_\_\_
7. Do you have any history of drug, alcohol abuse or dependency? NO \_\_\_\_\_ YES \_\_\_\_\_
8. Do you have any heart murmurs, or do you have to take any antibiotics prior to dental work?  
 NO \_\_\_\_\_ YES \_\_\_\_\_
9. Are you a diabetic, or has a doctor ever told you that you are a borderline diabetic?  
 NO \_\_\_\_\_ YES \_\_\_\_\_
10. Do you have any family member that has had any severe reaction to medication prescribed by a doctor?  
 NO \_\_\_\_\_ YES \_\_\_\_\_
11. Have you had any surgical procedures whatsoever to your head or neck, and if so, what?  
 NO \_\_\_\_\_ YES \_\_\_\_\_
12. Do you form unsightly scarring with cuts or scratches? NO \_\_\_\_\_ YES \_\_\_\_\_
13. Have you ever suffered from Peptic ulcers? NO \_\_\_\_\_ YES \_\_\_\_\_
14. Have you tested positive for Hepatitis A,B, or C? NO \_\_\_\_\_ YES \_\_\_\_\_ Please specify: \_\_\_\_\_
15. Have you tested positive for HIV or AIDS? HIV: Positive \_\_\_\_\_ Negative \_\_\_\_\_ AIDS: Positive \_\_\_\_\_ Negative \_\_\_\_\_
16. Do you smoke? NO \_\_\_\_\_ YES \_\_\_\_\_, if so, approximately how many cigarettes a day? \_\_\_\_\_
17. Have you smoked in the past and if so how long ago? \_\_\_\_\_
18. Is there any other information about your health that would be important to discuss with the doctor? If so, please detail that information here:  
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