

Consultation and *medical form*

Please fill this in before your consultation. Everything you tell us is confidential, and it helps us make sure SMP is safe and right for you. If anything's unclear, leave it and we'll go through it together.

ABOUT YOU

FULL NAME

DATE OF BIRTH

ADDRESS

POSTCODE

MOBILE

EMAIL

EMERGENCY CONTACT NAME

EMERGENCY CONTACT PHONE

GP SURGERY Optional

YOUR HAIR

WHAT WOULD YOU LIKE HELP WITH?

- ☐ Receding hairline ☐ Thinning crown ☐ Full head ☐ Density with longer hair ☐ Scar camouflage
☐ Not sure yet

WHAT HAS CAUSED YOUR HAIR LOSS, AS FAR AS YOU KNOW?

- ☐ Pattern hair loss ☐ Alopecia ☐ Cancer treatment ☐ Another medical condition ☐ Not sure

HOW LONG HAVE YOU BEEN LOSING HAIR?

IS IT STILL CHANGING?

- ☐ Yes ☐ No ☐ Not sure

HAVE YOU HAD ANY OF THESE?

- ☐ A hair transplant ☐ SMP or a scalp tattoo before ☐ Laser or other scalp treatment

IF SO, WHAT AND WHEN?

DO YOU USE ANY HAIR LOSS TREATMENTS, SUCH AS MINOXIDIL OR FINASTERIDE?

- ☐ Yes ☐ No

IF YES, WHICH ONES?

YOUR HEALTH

Tick yes or no for each question, and add details where you can. A yes doesn't usually rule you out. It helps us plan your treatment safely.

QUESTION	YES	NO	DETAILS
1 Are you having, or have you had, cancer treatment such as chemotherapy, radiotherapy or immunotherapy? When was your last treatment?	☐	☐	
2 Do you have diabetes?	☐	☐	
3 Do you have a heart condition, or a pacemaker or other implanted device?	☐	☐	
4 Do you have a bleeding disorder, or take medicine that thins your blood, including daily aspirin?	☐	☐	
5 Do you have epilepsy, or a history of seizures or fainting?	☐	☐	
6 Do you have high or low blood pressure?	☐	☐	
7 Do you have a condition, or take medicine, that affects your immune system or how you heal?	☐	☐	
8 Do you have psoriasis, eczema, dermatitis or any other condition on your scalp?	☐	☐	
9 Do you have an autoimmune condition, such as alopecia areata or lupus?	☐	☐	
10 Have you ever had keloid or raised scarring?	☐	☐	
11 Do you have any allergies, for example to latex, metals, plasters, antiseptics or local anaesthetic?	☐	☐	
12 Have you taken isotretinoin (Roaccutane) in the last 12 months?	☐	☐	
13 Are you pregnant or breastfeeding?	☐	☐	
14 Are you taking any other medicines or supplements? Please list them	☐	☐	
15 Is there anything else about your health we should know?	☐	☐	

YOUR DECLARATION

- ☐ I'm 18 or over.
- ☐ The information I've given is true and complete, as far as I know. I'll tell Blackline Clinic about any change to my health or medicines before each session.
- ☐ I agree to Blackline Clinic keeping this information, including my health details, as part of my treatment record. It will be kept securely and confidentially, and only shared with my permission or where the law requires it.

YOUR SIGNATURE

DATE