

DONOVAN

FIRST NAME: _____

LAST NAME: _____

PART 1. BEFORE STARTING ORAL MINOXIDIL, Please measure your blood pressure on three separate occasions before starting. You will also need to measure your weight just ONCE before starting. Please email these results to office@donovanmedical.com

	DATE	HEART RATE	BLOOD PRESSURE
MEASUREMENT 1			
MEASUREMENT 2			
MEASUREMENT 3			

MY CURRENT WEIGHT (before I started minoxidil): _____

PART 2. AFTER STARTING ORAL MINOXIDIL (or anytime after a change in dose), Please measure your blood pressure at the **end of week 1, at the end of week 2, and at the end week 3. Also measure **ANYTIME** you feel dizzy. Please email these results to office@donovanmedical.com**

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