Hair Growth
CONFIDENTIAL QUESTIONNAIRE

Name: _____Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work phone: _____

DOB: _____ Age: _____ Occupation: _____

E-mail Address: _____

Referred by: ○ Doctor ○ Google Search ○ Facebook ○ Instagram ○ TikTok ○ Internet ○ Social Media ○ TV ○ Radio

Salon: _____ Other: _____

If other who referred you? _____

Personal History:

Allergies: _____ Are you allergic to shellfish? ○ Yes ○ No

General Health: _____

Previous Surgery with General Anesthesia: _____

Do you have any of the following issues?

○ Stroke ○ Congestive Heart Failure ○ Irregular Heartbeat ○ Hypertension Coronary Artery Disease ○ Anemia ○ Depression ○ Thyroid Disease ○ Endocrine Disorders ○ Diabetes ○ Liver Disease ○ Rosacea

Presently undergoing treatment for: _____

Physician's name: _____ Date of last physical: _____

Stress: ○ High ○ Medium ○ Low

Medications:

Please list the name(s) of medication(s) and dosage(s) if applied.

Anti-coagulants: _____ Anti-hypertensive: _____

Hormones: _____ Thyroid: _____ Aspirin: _____ Multivitamins: _____

Radiation Therapy: _____ Chemotherapy: _____

Taking any medication or supplements? Please List: _____

Females Only

Female issues: ○ Yes ○ No Postmenopausal: ○ Yes ○ No

Are you planning to get pregnant in the next 6 months? ○ Yes ○ No

Are you currently pregnant or nursing? ○ Yes ○ No

Do you take Contraceptive Pills? ○ Yes ○ No

How long have you taken them? _____

Males Only

Have you currently had or plan to take a PSA blood test for the screening of prostate cancer? ○ Yes ○ No

Do you have an enlarged prostate, prostate cancer? ○ Yes ○ No

Nutrition:

Are you a vegetarian? ○ Yes ○ No

How many daily servings of protein? _____

Fruit: _____ Vegetables: _____ Caffeine: _____

Carbohydrates: _____ Protein: _____ Lost weight recently? ○ Yes ○ No

How much? _____

HAIR & SCALP Condition(s):

Is your Scalp: ○ Dry ○ Oily ○ Normal ○ Dandruff

Any Redness or itchy scalp: ○ Yes ○ No Do you pull your hair? ○ Yes ○ No

Any Bumps or raised areas: ○ Yes ○ No Recurrent attacks of patchy loss: ○ Yes ○ No

Hair of different lengths: ○ Yes ○ No Areas of hair loss: ○ All over scalp ○ Front ○ Crown

Any loss of hair on body? ○ Yes ○ No What area? _____

At what age did you notice hair loss? _____ ○ Sudden ○ Gradual

Is your hair loss getting worse? _____ How many hairs lost per day? _____

What kind of shampoo do you use? _____ Conditioner? _____

How many times per week do you shampoo? _____

Do you use a hair dryer? ○ Yes ○ No What temperature? ○ Hot ○ Medium ○ Cool

When hair is wet, do you use a towel to rub dry? ○ Yes ○ No

Do you color your hair? ○ Yes ○ No How often? _____

Is your hair loss concern caused by any medical problems or medications that you are aware of?

_____

Heredity:

Does hair loss run in your family? Insert ○ Yes ○ No in the chart below.

	BALD	THINNING HAIR	NOT BALD	UNKNOWN
Parents				
Grandparents				
Siblings				
Aunt				
Uncle				

What options have you researched for your hair loss (Including over the counter and prescriptions)?

○ Growth Factors ○ Low-Level Laser Therapy ○ Platelet-rich plasma ○ Rogaine / Minoxidil 5%

○ Finasteride / Propecia ○ Laser Cap ○ Microneedling ○ Transplants ○ Hair Replacement / Wigs

○ SMP ○ XTC ○ HLCC ○ Bosley ○ Hair Club ○ Keeps ○ Hims / Hers ○ Nutrafol ○ Keranique

○ Other _____ ○ Other _____ ○ Other _____

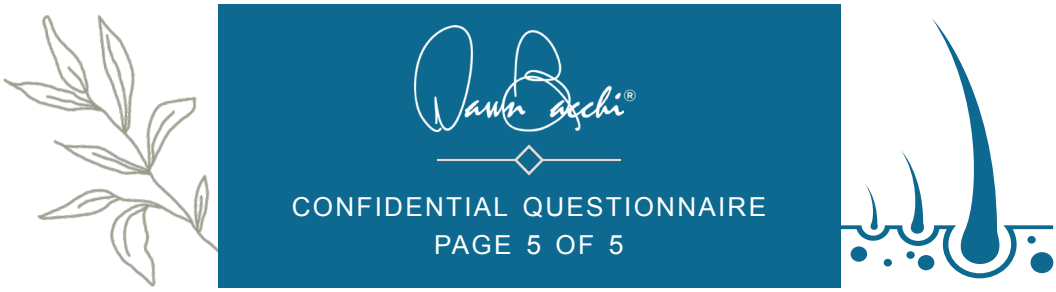
How much does your hair loss bother you? ○ Slightly ○ Moderately ○ Highly

Did you tell anyone that you were coming here today? ○ Yes ○ No

What are your goals and expectations?

○ Prevent further loss ○ Gain back hair quickly ○ Gradually gain back some hair

○ Other: _____



Knowing that treatment and/or surgical options may take 6 months or more to show success, are you willing to wait that long? ○ **Yes** ○ **No**

Please indicate where hair loss bothers you the most.

- ○ **No variation in hairstyle**
- ○ **Going outside on windy days**
- ○ **Social Life**
- ○ **Seeing old friends**
- ○ **Participating in sports**
- ○ **Overall appearance**
- ○ **Conscious of appearance at work**
- ○ **Seeing pictures/videos**
- ○ **Wearing hats when going out**
- ○ **Swimming or getting caught in the rain**
- ○ **Overall self-esteem**
- ○ **Meeting new people**
- ○ **People make comments**

Consent for treatment

I agree to be evaluated and I understand I will first undergo a comprehensive preliminary evaluation by an experienced consultant. All other checkups are included with the program's cost, which includes monthly and/or quarterly digital and microscopic pictures, for which I give my consent. I further understand results will vary depending on a large number of factors. I acknowledge that it is my responsibility to the company for any changes in my condition, no matter how slight.

I understand some general recommendations will be made based on the initial consultation

SIGNATURE: _____ DATE: _____