



Name: _____ DOB: _____

HAIR CONCERNS

What Hair Loss concerns bring you to Elle Med Spa today?

How long has this been bothering you?

Was there any event that seemed to bring it on? [] Yes [] No

If yes, Please explain: _____

Are there any other symptoms associated with hair loss such as itching, rash, redness or rashes elsewhere? [] Yes [] No

If yes, Please explain _____

Is there hair loss just on the scalp? [] Yes [] No

If yes, Please explain: _____

Is there anything that seems to make it worse? [] Yes [] No

If yes, Please explain: _____

Has anything improved it? [] Yes [] No

What have you tried? _____

Do you have a family history of hair loss or baldness? [] Yes [] No

If yes, please explain: _____

Have you recently had lab tests for your thyroid function, iron/ ferritin, Vitamin D? [] Yes [] No

Any recent stress, trauma or surgery? [] Yes [] No

If yes, Please explain _____

For Women:

Do you suffer from irregular menses, infertility, facial hair or acne? [] Yes [] No

Are you pregnant or trying? [] Yes [] No

Have you ever been diagnosed with Polycystic Ovarian Syndrome (PCOS)? [] Yes [] No

Last menstrual period (LMP): _____ / _____ / _____

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Do you take any of the following: (circle)

Acitretin

Gemfibrozil

Levodopa

Amantadine

Cimetidine

Lithium

Amiodarone

Colchicine

Methotrexate

Anticoagulants

Hormones

Propranolol

Anticonvulsants

Isotretinoin

Valporic Acid

Captopril

Ketoconazole

List of supplements, nutrition and lifestyle recommendations will be discussed upon consultations.

Clinical Use Only