**CONFIDENTIAL CONSULTATION QUESTIONNAIRE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: TV AD □ Internet □ Yellow Pages □ Radio □ Salon □ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal History:**

Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you allergic to shellfish?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

General Health\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Surgery with General Anesthesia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any of the following issues?

Stroke □ Congestive Heart Failure □ Irregular Heart Beat □ Anemia □

Hypertension (High Blood Pressure) □ Coronary Artery Disease □ 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 name of medication and dosage

Anti-coagulants\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anti-hypertensive\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hormones\_\_\_\_\_\_\_\_\_\_\_ Thyroid\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Aspirin\_\_\_\_\_\_\_\_\_\_

Multivitamins\_\_\_\_\_\_\_\_\_\_

Radiation Therapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chemotherapy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Taking any medication or supplements? Please List

**\*Females Only\***

Female issues: Yes □ No □ Post Menopausal: 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?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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?**  Yes □ No □

**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? Yes □ No □

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **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)?**

Transplants □ Scalp Treatments □ Hair Replacement/ weaves □

Over the counter products □ Prescription products □ Avacor □

Minoxidil\_\_\_\_\_\_% Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clubs or Hair Loss Clinics\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 hair style ◻ Seeing pictures/videos □

Going outside on windy days □ Wearing hats when going out □

Social Life □ Swimming or getting caught in the rain □

Seeing old friends □ Overall self esteem □

Participating in sports □ Meeting new people □

Overall appearance □ People make comments □

Conscious of appearance at work ◻

**Consent for treatment**

I agree to being evaluated and I understand I will first undergo a comprehensive preliminary evaluation by an experienced consultant. All other checkups are included with the cost of the program, which include 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 of any changes in my condition, no matter how slight.

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

SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_