Name: _____Date: _____

Address: _____

City: _____State_____Zip_____

Home Phone_____Work phone_____

DOB_____ Age_____

Occupation_____

E-mail Address_____

Referred by: TV AD ___ Internet___ Yellow Pages___ Radio___ Health & Wellness Expo_____

Salon_____ Other _____

Medical History

Allergies_____Are you allergic to shellfish?_____

General Health_____

Previous Surgery with General Anesthesia_____

Do you have any of the following medical problems?

Stroke Congestive Heart Failure Irregular Heart Beat Coronary Artery Disease Hypertension (High Blood Pressure) Anemia Depression Thyroid Disease

Presently Undergoing Medical Treatment for _____

_____

Physician's name_____ Date of last physical_____

Stress: High_____ Medium_____ Low_____

Blood work: Have you had any of these tests done in the past year?

CBC w/Diff Thyroid Panel Glucose Tolerance Ferritin/Iron test

Hormone: DHEA/Testosterone /Estrogen Other_____

Medications: Please list the name of any medication (or supplement) and dosage you take daily

_____

_____**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 How many weeks?_____

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 servings of protein do you get a week?___

Serving red meat ***per week***_____ Snacks_____

Gained or lost weight recently?_____ How much?_____

Conditions of Hair and Scalp

Scalp: Dry___ Oily ___ Redness Yes___ No___ **Dandruff** Yes___No___

Painful itchy scalp: Yes___No___ **Itchy scalp only:** Yes___No___

Do you pull your hair? Yes___No___

Bumps or raised areas: Yes___ No___ **Goose Bump feeling:** Yes___ No___

Recurrent attacks of patchy loss: Yes___No_ **Hair of different lengths** Yes___ No___

Areas of hair loss: All over scalp___ Front___ Crown___

Alopecia Areata____ Totalis___ Universalis___

Did you lose any hair at a young age? Yes___ No___ How old were you?_____

Any loss of hair on body? Yes___No ___ What area_____

At what age did you notice hair loss?_____ Was loss sudden?_____ or 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___

Is your hair loss 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 or 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___

Would you like to consider using prescription strength topical and pills if you could get better results? Keep in mind, prescription products in general increase the cost 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 ___