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HAIR, SCALP AND HAIRCARE HISTORY

It is very important that the information given is complete and accurate in order for me to provide you the best healing experience possible. Please PRINT clearly. If you have questions, please ask. All information provided is confidential.

Today's Date: _____/_____/_____

GENERAL INFORMATION

Legal Name _____ Preferred Name/Nickname _____

Date of Birth _____ Gender Identity/Pronoun(s) _____

Address _____ City _____ State _____ Zip Code _____

Preferred Phone Number (_____)_____ Ok to leave a medical related voicemail at this number? ____ Y ____ N

Email address _____ Ok to send medical related messages to this email? ____ Y ____ N

Minors Under 18 - Parent/Responsible Party Information

Name _____ Relationship to Patient _____

Date of Birth _____ Phone Number (_____)_____

EMERGENCY CONTACT

Name _____ Relationship to Patient _____

Phone Number (_____)_____

HAIR AND SCALP HISTORY AND HEALTH

What type of hair loss are you experiencing (please check off all that apply)?

____ Bald patches ____ Excessive shedding ____ Overall thinning ____ Less than 100 hairs per day ____ More than 100 hairs per day

Areas affected by hair loss:

____ Top of Scalp ____ Front of Scalp ____ Sides of Scalp ____ Back of Scalp ____ Eyebrows ____ Eyelashes

When did your hair loss start (approximately)? _____

Was onset of hair loss: ____ Sudden ____ Gradual Since onset, has it gotten: ____ Better ____ Worse ____ Stayed the same

Associated symptoms of the scalp:

Itch? ____ No ____ Mild ____ Moderate ____ Severe Burning? ____ No ____ Mild ____ Moderate ____ Severe

Tender or Painful? ____ No ____ Mild ____ Moderate ____ Severe

Flaking? ____ Y ____ N Greasy? ____ Y ____ N Redness? ____ Y ____ N Bumps or Sores? ____ Y ____ N

Associated symptoms of the hair (check all that apply):

____ Frizziness ____ Texture Change ____ Wave Pattern Change ____ Hair of Different Lengths ____ Color Change (non-cosmetic)

What treatments for hair loss have you previously tried and for how long? _____

_____

What treatment are you currently using for hair loss (medications, Rogaine, vitamins, shampoos, etc.)? _____

_____

Any side effects from treatments (i.e. scalp irritation, dizziness, hair growth in unwanted areas, breast enlargement, etc)? ___Y ____ N

If yes, please explain: _____

Have you seen a medical doctor or dermatologist for this problem? ___Y ____ N

If yes, please list any diagnosis, medications, or recommendations given: _____

_____

Have you ever had a biopsy or culture done on your scalp? ____ Y ____ N

If yes, what, what were the results? _____

HAIR CARE PRACTICES

How often do you wash your hair? _____

What hair products do you use:

Shampoo: _____

Conditioner: _____

Other hair products:_____

Do you use any of the following?:

____ Blow dry ____ Hot rollers ____ Relaxer/Keratin ____ Hair dye ____ Rollers ____ Curling iron ____ Straightener

____ Perm _____ Other _____ Other

How often do you use any of the above? _____

Do you regularly have any of the following hair styles:

____ Ponytails ____ Headbands. ____ Weaves ____ Braids ____ Extensions ____ Twists ____ Dreadlocks

How often do you use any of the above? _____

HEALTH AND MEDICAL INFORMATION AND HISTORY

Do you take any medications, supplements or herbs? ____ Y ____ N If yes, please list: _____

_____

Do you have any allergies? ____ Y ____ N If yes, please list: _____

Have you recently dramatically changed your diet? ____ Y ____ N f yes, please describe: _____

Are you a vegetarian? ____ Y ____ N If yes, for how long have you followed this diet? _____

Are you a vegan? ____ Y ____ N If yes, for how long have you followed this diet? _____

Are you following any other diets or have any dietary restrictions (gluten free, low protein, KETO, etc) ____ Y ____ N

If yes, what is the diet or restriction, and for how long have you followed this diet or restricted? _____

_____

Do you see a rash in your scalp or on your face? ____ Y ____ N If yes, please describe: _____

_____

Are you on any type of hormone treatment? ____ Y ____ N If yes, what type and for how long? _____

Do you have:

____ Psoriasis ____ Dandruff ____ Excess body or facial hair ____ Anemia ____ Lichen Planus ____ Cystic Acne ____ High Blood Pressure

____ Hyper or Hypothyroid ____ Syphilis ____ Deepening of voice ____ Breast discharge ____ Polycystic ovary disease ____ Diabetes

____ Anxiety ____ Depression ____ Liver Disease ____ Any autoimmune disease (please list): _____

In the last 3-12 months, have you experienced?

____ Start or stop beta blocker medication ____ Start or stop hormone treatment ____ Start or stop birth control pills

____ Childbirth ____ Severe infection ____ High fever ____ Flare of chronic illness ____ Severe psychological stress

____ Major surgery ____ Low iron ____ Over or under active thyroid ____ Weight loss ____ Weight gain

Please explain if you checked any of the above: _____

Do you smoke or vape? ____ Y ____ N ____ Former If yes, what, and how much/how often per day?_____

Do you drink alcohol? ____ Y ____ N If yes, how much and how often? _____

Do you drink caffeinated drinks, including coffee and tea? ____ Y ____ N

If yes, what, and how much/how often per day?_____

How much water per day do you drink? _____

Describe your energy level:

____ *Low*; tired most of the time ____ *Fluctuating* between morning and afternoon ____ *High*; lots of energy and endurance

Describe your average daily food/calorie intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

How would you rate your current nutritional status?:

____ Poor ____Fair ____ Satisfactory ____ Good ____ Excellent

How many days per week do you exercise? _____0-1 _____1-2 _____2-3 _____3-4 _____4-5 _____5-6 _____6-7 _____7 days

How many hours of sleep per night do you get? _____ What time do you go to bed? _____ What time do you wake up? _____

Do you have trouble falling asleep? ____ Y ____ N Do you have trouble staying asleep or wake up frequently? ____ Y ____ N

Do you wake up feeling rested? ____ Y ____ N

How would you rate the condition of your health?:

____ Poor ____Fair ____ Satisfactory ____ Good ____ Excellent

How would you rate your current stress management skills?:

____ Poor ____Fair ____ Satisfactory ____ Good ____ Excellent

How does hair loss affect you? How does it make you feel? _____

_____

FAMILY HISTORY

Any hair loss in men in your family? ____ Y ____ N If yes, what is their relation to you? _____

Does their hair loss appear similar to yours? ____ Y ____ N

Any hair loss in women in your family?____ Y ____ N If yes, what is their relation to you? _____

Does their hair loss appear similar to yours? ____ Y ____ N

Any family history of thyroid disease, anemia, polycystic ovarian disease, or lupus?____ Y ____ N

If yes, what is their relation to you? _____

Any family history of breast cancer or ovarian cancer? ____ Y ____ N

If yes, what is their relation to you? _____

FEMALE PATIENTS ONLY

Are you currently pregnant? ____ Y ____ N If yes, how many weeks?: _____ Are you trying to get pregnant? ____ Y ____ N

Are you currently nursing/breastfeeding? ____ Y ____ N

Do use you use any form of hormone-based contraception? ____ Y ____ N

If yes, what type and for approximately how long? _____

Or if you have recently stopped taking it, when did you stop? _____

Have you recently started, stopped, or changed brands of birth control including oral or implantable methods? ____ Y ____ N

If you are premenopausal, are your menstrual periods (check all that apply):

____ Regular ____ Irregular ____ Light ____ Moderate ____ Heavy ____ Bloodclots

Do you experience any of the following PMS symptoms? (check all that apply):

____ Tender Breasts ____ Cramps ____ Bloating ____ Back Pain ____ Mood Swings ____Headaches/Migraines ____ Sleep Disturbances

Have you gone through menopause? ____ Y ____ N ____ Currently experiencing If yes, what age did it begin? _____

If currently experiencing, do you suffer from any of the following? (check all that apply):

____ Hot flashes ____ Night Sweats ____ Excessive Vaginal Dryness

Have you had a hysterectomy? ____ Y ____ N If yes, for what reason and approximately how long ago? _____

_____

Do you use hormone replacement therapy? ____ Y ____ N

Please write in any additional information you think I may need to know in order to best serve you: _____

_____

_____