Name: _____ **Date of Birth:**_____

Address: _____

Phone Number: _____ **Email:** _____

How did you hear about us? _____

Where is your hair loss?

☐ Scalp ☐ Eyebrows ☐ Beard ☐ Other: _____

How did the hair loss occur?

☐ Gradual (slow, advancing step by step) ☐ Sudden (happened quickly)

How severe is your hair loss?

☐ Mild (25% or less of hair lost) ☐ Moderate (25-75% of hair lost) ☐ Severe (75% or more of hair lost)

How long have you had hair loss (please specify in numbers)?

☐ Years: _____ ☐ Month: _____ ☐ Weeks: _____

Does your scalp have any of the following symptoms?

☐ No symptoms ☐ Bumps ☐ Redness ☐ Scaling ☐ Burning
☐ Drainage ☐ Itching ☐ Flaking ☐ Tenderness
☐ Other: _____

Please check all that apply:

☐ A recent hospitalization ☐ Anemia ☐ Hypothyroid ☐ Hyperthyroid
☐ Unintentional weight change ☐ A recent surgery ☐ A systemic disease ☐ A recent illness
☐ None of the above

Have you had any previous bloodwork/labs done (Ferritin, TSH, etc)?

☐ Yes – If so, when? _____ ☐ No

What are you currently taking or using to treat hair loss?

☐ Biotin ☐ Propecia/Finasteride ☐ Clobetasol ☐ None/No treatment
☐ Minoxidil 2% (Rogaine) ☐ Minoxidil 5% (Rogaine) ☐ Other: _____

Who in your family has or had hair loss/thinning/balding?

☐ Mother	☐ Father	☐ Aunt	☐ Uncle	☐ Cousin
☐ Sister	☐ Brother	☐ Son	☐ Daughter	
☐ Grandfather-Maternal	☐ Grandmother-Paternal	☐ Grandfather-Paternal	☐ Grandmother-Maternal	

To track progress, we will be taking pictures of your scalp: top, sides, forehead, whatever is applicable. No identifying features will be photographed, such as your face. Would you allow us to share updates on social media of your treatment? No names or other identify information will be used.

☐ Yes ☐ No

Additional History (for example, have you been diagnosis with a hair/scalp condition?):

_____

_____

_____

_____

_____

_____

I have answered all the questions truthfully and to the best of my knowledge.

Signature: _____ Date: _____