MARTINE LANGSAM, IAT, WTS - Trichology Clinic
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In order to assist you with hair loss and scalp issues, I need to receive the following information from you in the following questionnaire. All information is strictly confidential and will not be shared or used for any purpose other than to assist you in the following process of hair restoration. I do not cure, diagnose, or treat.

Do not wash your hair or apply hair fibers the day of your consultation. It is helpful to see the condition of your scalp. Thank you!

Name:_____Date:_____
Address:_____
_____

Telephone: (hm)_____(cell)_____
Email:_____

Age:_____ Birthdate:____/_____/_____ Sex:_____ Race:_____
Occupation:_____

How did you hear about me?_____

Reason for visit:
_____
_____

History of present problem:
_____
_____
_____
_____

Medical

Height:_____ Weight:_____ Children:_____(Ages)_____
Smoking:_____(P/day)_____Drinking:_____(glasses/week)_____

Are you currently or within the past 6 months been under a physician's care?
Yes__ No___

Are you currently seeing a doctor for any medical conditions that are not yet completely diagnosed? Yes No

Do you have any of the following medical conditions (check all that apply)

Diabetes___ High blood pressure____ Skin lesions____ Hormone imbalance____
Heart disease____ Stroke_____ Thyroid ____ Hormone: DHEA____ Testosterone_____ Stress____

Illnesses/Infections:_____Injuries:_____

Disease:_____ Sleeping hours p/night:_____

Stomach problems:_____ Surgery/Hospitalization:_____
_____

Emotional factors/Stress:_____
_____

Medications (list if past or present):
_____
_____
_____
_____

Drug reactions:_____ Abnormal Blood tests: _____(Please include any recent lab tests) _____
_____
_____

Chinese medicine:_____ Supplements: _____
_____
_____

Hormone drugs:_____Steroids:_____
Periods:_____ Oral contraceptives:_____

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

Males Only
Have you 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

Conditions of Hair and Scalp

Which of the following best describe your scalp type? Please check all that apply. Dry___
Oily___ Flaky ___ Normal___ Sensitive___ Dandruff___ Redness___ Bumps___ ingrown hairs___

Which of the following best describe your hair type? Thin texture____ Medium texture___ Thick texture___

Frequency of shampooing:_____ Hair products (type/brand):_____
_____
Heat appliances:_____ Sun Exposure:_____

Hair Loss

Areas of hair loss; please check all that apply. All over scalp___ Front___ Top___ Sides___ Crown___

Recurrent attacks of patchy loss: Yes No

At what age did you start to notice hair loss, or hair thinning out? ___

Which area did you first start to loose hair? _____Was your hair loss sudden, or happened over time? _____Has your hair loss gotten worse? _____

Have you tried different hair loss products? _____Which Hair loss products have you tried? _____

Do you use Minoxidil or Rogaine? _____ If so how long have you been using it? _____ How often do you use it?_____

What options have you researched for your hair loss (Including over the counter and prescriptions)? _____

Does hair loss run in your family? Yes No Parents___ Grandparents___ Brothers___ Sisters___

Knowing that treatment and/or surgical options may take 6 months or more to show success, are you willing to wait that long?_____

What are your goals and expectations? Prevent further loss? ___Gain back hair quickly? ___ Gradually gain back some hair_____ Other_____

Nutrition

Are you a Vegetarian? Yes No

How many servings of protein grams do you get a day? _____

Serving red meat per week:_____ Snacks:_____

Any food sensitivities or allergies? _____

Gained or lost weight recently? _____ How much? _____

Any other information or comments you would like to add:

_____

_____

_____

_____