Trichology

Consultation Form

Name: Date:

Address:

Phone: E-mail:

Emergency Contact Name: Emergency Contact #:

How did you hear about us?

Medical History (Select All That Apply):

Please check any of the following that apply to you:

- ☐ Psoriasis
- ☐ Seborrheic dermatitis
- ☐ Double vision
- ☐ Cystic Acne
- ☐ Enlargement of clitoris
- ☐ Excess facial hair
- ☐ Excess body hair
- ☐ Discharge from breast
- ☐ Deepening of voice
- ☐ Polycystic ovary disease
- ☐ History of autoimmune disease (please list): _____

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

- ☐ High fever
- ☐ Childbirth
- ☐ Severe infection
- ☐ Flare of chronic illness
- ☐ Major surgery
- ☐ Start or stop beta blocker medication
- ☐ Start or stop hormone treatment
- ☐ Start or stop birth control pills
- ☐ Severe psychological stress
- ☐ Low iron in blood

Have you ever had an allergic reaction?_____

Other Medical Concerns:_____

Family History (Select All That Apply):

Any hair loss in men in your family? ○ Yes ○ No If Yes, Who?_____

Any hair loss in women in your family? ○ Yes ○ No If Yes, Who?_____

Health History (Select All That Apply):

Have you recently dramatically changed your diet? ○ Yes ○ No

Are you a vegetarian? ○ Yes ○ No

Do you see a rash in your scalp or on your face? ○ Yes ○ No

If Yes, Please Describe:_____

Are you on any type of hormone treatment? ○ Yes ○ No

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

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

What treatments have you previously tried and for how long?

Female Patients Only

Are you using a hormonal birth control? ○ Yes ○ No

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

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

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

○ Regular ○ Irregular ○ Light ○ Moderate ○ Heavy

Have you gone through menopause? ○ Yes ○ No

If YES, what age?_____

History of Hair Loss and Scalp Health

When did your hair loss start (approximately)?_____

Where are you experiencing hair loss? ○ Scalp ○ Other areas:_____

Is your hair loss: ○ General ○ Patches ○ Both

Was onset of hair loss: ○ Sudden ○ Gradual

Since onset, has it gotten: ○ Better ○ Worse ○ Stayed the same

Is your hair: ○ Thinning ○ Shedding ○ Both

Does your scalp itch? ○ No ○ Mild ○ Moderate ○ Severe

Is your scalp flaking? ○ Yes ○ No

Hair Care and Styling

How often do you wash your hair?_____

What hair products do you use?_____

Do you use:

- ☐ Hot rollers
- ☐ Relaxer/Keratin?
- ☐ Hair dye
- ☐ Rollers
- ☐ Curling iron
- ☐ Straightening iron
- ☐ Other hair treatment chemicals:_____

Do you regularly have any of the following hair styles:

- ☐ Ponytails
- ☐ Weaves
- ☐ Braids
- ☐ Extensions
- ☐ Dreadlocks
- ☐ Twists
- ☐ Headbands

How often do you use any of the above?_____

Client Statement

I hereby confirm that all information provided in this form is true, accurate, and complete to the best of my knowledge and belief.

I understand that it is my responsibility to inform the business promptly of any changes to my contact information, or medical history as this could have an effect on the course of treatment provided.

Signature: _____ **Date (dd/mm/yyyy):** _____