Patient Information

All information contained in this questionnaire is strictly confidential, will be protected to the highest of HIPPA standards, and will become part of your Restorative Health Record

Patient Information:

Name:____ Date:________________________

Last First Middle

Date of Birth:___________________ Age in Yrs:______________ Occupation:______________________________________

Home Address:____

City:____ State:___________________ Zip:___________________

Home Phone:______________________ Cell Phone:__________________________ Work Phone:________________________

E-Mail Address:____ May we contact you via E-Mail Yes No

How do you prefer to be contacted? Phone Email Text Other_________ May we leave a voice mail? Yes No

Marital Status (check one): Married Seperated Divorced Widow(er) Living with Sig Other Single

Spouse or Sig Other Name:____Phone:_____________________________

In Case of an Emergency Contact:_______________________________________ Relationship:__________________________

Driver's License Number:____

Primary Care Physician Name:____Speciality: __________________________

Preferred Pharmacy:____ Phone:_____________________________

How did you hear about us? TV Radio Web Pandora Social Media Referral

If you were referred, who referred you? ____

Would you like to receive special offers and promotions from Restorative Health via e-mail? Yes No

What are your top 4 goals you would like to accomplish in or program (please put in order of importance)?
1.
2.
3.
4.

Have you ever had or do you have any of the following?:

- Anemia
- Abnormal Wght Loss/Gain
- ADD/ADHD
- Anxiety
- Bipolar
- Bleeding Disorder
- Blood Pressure (high or low)
- Cancer
- Celiac
- Connective Tissue Disorder
- Crohn's / IBS
- Depression
- Diabetes
- Drug Abuse
- Eating Disorder
- Eczema
- Epilepsy/Seizures
- Excessive Fatigue
- Excessive Stress
- GERD / Ulcers
- Genital Herpes
- Headaches
- Heart Disease
- High Cholesterol
- HIV or AIDS
- Implants (Breast/Other)
- Keloid Scarring
- Kidney Disease
- Liver Disease/Hepatitis (A,B, C)
- Lyme Disease
- Memory Loss
- Oral Herpes or Cold Sores
- Osteoporosis / Osteopenia
- PCOS
- Pacemaker or Palpitations
- Psoriasis
- Respiratory Condition
- STD's
- Stroke
- Thyroid Disorder
- TIA's
- Transplant
- Urinary Incontinence

Please describe or explain any of the above:____

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Other Medical Issues: ____

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Current Prescription Medication, Over the Counter Medication and Supplements

Name of Medication / Supplement	Reason for Taking	Strength	Dosing Instruction
Example: Tylenol	Headaches	500mg	1 tab 3 times per day

Allergies to medicine, supplements, vaccines, foods, environmental or other substances

Substance	Reaction
Example: Penicillin	Hives, Swelling, Shortness of Breath

Past Surgical and Hospitalization History

Surgery and / or Hospitalization	Date

Family History

Illness	Mother	Father	Brothers	Sisters	Grand Mother	Grand Father
	Alive Y N	Alive Y N	How Many?_____	How Many?_____	Alive Y N	Alive Y N
			How Many Alive?_____	How Many Alive?_____		
Anxiety						
Bi-Polar						
Bleeding Disorder						
Breast Cancer						
Colon Cancer						
Depression						
Dementia / Alzheimer's						
Diabetes						
Heart Disease						
High Blood Pressure						
Lung Cancer						
Headaches (Migraine)						
Osteoporosis						
Ovarian Cancer						
Prostate Cancer						
Stroke						
Thyroid (hyper/hypo)						
Other:						
Other:						

Staff Notes:

Social History

Do you smoke? Y N If yes – how many packs per day?
If no – have you ever smoked? Y N If yes, when did you quit?
Type of tobacco used: Cigarettes Cigar Chew Pipe Other:

Do you drink alcoholic beverages? Y N
If yes – how many drinks per week?

Do you use any street drugs (i.e. marijuana, cocaine etc) Y N
If yes – which drugs do you use?

Do you drink coffee? Y N
If yes – how many cups per day?

Do you drink caffeinated beverages? Y N
If yes – how many beverages per week?

Recent significant changes in your life? Y N
If yes – please explain:

Dissatisfied with current employment? Y N
If yes – please explain:

Special stressors in your life? Y N
If yes – please explain:

In an abusive relationship (physical, verbal, sexual)? Y N
If yes – please explain:

Children? Y N
If yes – how many sons? daughters?
Name and ages of your children:

Your Hair Loss

When is your earliest memory of your hair density changing (approximate date (i.e. Oct 2000)? ________________________________

Do you have less hair on the scalp than you had 6 months ago? Yes No 12 months ago? Yes No

If you had to "guess", how much hair would you say you've lost: 10% 20% 30% 40% 50% 60% 70% 80% 90%

Have you been given any of the following diagnoses for your hair loss?

No, I've never been given a diagnosis as to the cause of my hair loss
Female genetic hair loss (androgenetic alopecia)
Alopecia Areata Hair shedding (Telogen Effluvium)
Lichen Planopilaris (LPP)
Folliculitis Decalvans
Frontal Fibrosing Alopecia (FFA)
Discoid Lupus (DLE)
Pseudopelade of Brocq
Trichotillomania
Dandruff
Seborrheic Dermatitis
Erosive Pustular Dermatosis
Central Centrifugal Ciciatricial Alopecia (CCCA)
Traction Alopecia Chemical Burn
Other:____

Have you ever had a scalp biopsy? Yes No When?________________________ Do you have the results? Yes No

Where on the scalp do you feel you have lost hair? (Check all that apply)

My temples have less hair
My front hairline has less hair
The front half of my head is thinner
The sides of my head (above the ears) has less hair
The very top of my head is thinner
The back of my scalp is thiner
Other:____

Overall, would you say that your hair loss/thinning is: Mainly in CERTAIN AREAS of the scalp Or would you say it's occurring ALL OVER THE SCALP?

My hair is curlier than it was 3 years ago? True False

Have you tried any type of treatment for your hair loss (topical medicines, prescription medications, shampoos)? Yes No

If YES, what have you tried (please list any including minoxidil (Rogaine), Finasteride (Propecia), PRP, Laser, Herbs, Vitamins, Supplements etc):

Treatments to Date	Still Yes	Using No	How long were or have you been on it?

Do you feel like any of these treatments helped you? Yes No If YES, how?____

____
____
____
____
____
____

Minoxidil (Rogaine) Use:

If you've used Minoxidil (Rogaine) in the past but stopped its use – when did you stop and why?______________________________

____

____

Which concentrations of minoxidil have you used?

I have used 2% minoxidil
I have used 5% minoxidil
I have used minoxidil at concentrations above 5%
I cannot remember the concentration of minoxidil I've used

Did you experience any side effects while on minoxidil? Yes No If YES, what side effects did you experience?__________________

____

____

Finasteride (Propecia) Use:

If you've used Minoxidil (Rogaine) in the past but stopped its use – when did you stop and why?______________________________

____

____

Which concentrations of finasteride have you used?

I have used 1mg dose (finasteride or Propecia)
I have used 5mg dose (finasteride or Proscar) and cut it into 4 pieces

Are you or have you experienced any of the following side effects on finasteride (Propecia)?

Decreased sex drive (libido)
Impotence
Problems with ejaculation
Executive decision dysfunction
Breast enlargement
Mood changes (depression)
Brain fog (clouded thinking)
Penile or testicular shrinkage

Other:____

Have you had any steroid injections (Kenalog) as part of your treatment? Yes No If YES, how many?______________________

Do you feel like the steroid injections helped? Yes No If YES, how?____

____

Have you ever used Accutane (also called Isotretinoin) in the past for any reason including the treatment of acne? Yes No

Have you ever had a hair transplant? Yes No If YES, when and how many graphs did you have?_____________________________

____

In the past 5 years, have you used any of the following?

Wig	Do you currently use?	Yes	No	How long have you used or did you use? _______________
Hairpiece	Do you currently use?	Yes	No	How long have you used or did you use? _______________
Topper	Do you currently use?	Yes	No	How long have you used or did you use? _______________
System Hair Extensions	Do you currently use?	Yes	No	How long have you used or did you use? _______________
Hair Camouflaging Fibers	Do you currently use?	Yes	No	How long have you used or did you use? _______________
DermMatch Camouflaging Powders	Do you currently use?	Yes	No	How long have you used or did you use? _______________

Other:____

In your opinion, do you think your hair extensions are causing some further hair loss? Yes No

If you use camouflaging products, how many days per week do you use them? 1 2 3 4 5 6 7

Do you color or dye your hair? Yes No

Compared to 5 years ago, do you feel like your hair is: Lighter Darker Has stayed the same

Do you have any gray hair? Yes No If YES, what age did you first develop gray hair?____

Have you had laser hair removal treatments to remove facial hair? Yes No

Do you feel like your hair is breaking off? Yes No

Do you ever get itching in the scalp? Yes No

If YES, how often do you get itching? Every day Once per week 2-3 times per week 4-6 tiimes per week A few times per month

What do you do to help stop your itching?____

Questions about your Scalp	Yes	No	Treatments you've used to relieve your symptoms
Does your scalp feel dry?			
Do you ever get burning in the scalp?			
Do you experience tingling in your scalp?			
Does your scalp ever feel tender/sore/ bruised?			
Does your hair hurt when you move your hair?			
Do you ever get pimples on your scalp			

Do you feel you are shedding more hair on a daily basis than you used to? Yes No If YES, how many hair per day:_____________________

Is your scalp easily bothered by shampoos, conditions, produts that you use? Yes No

How often do you shampoo your hair? ____

Do you presently use any of the following shampoos?

Head and Shoulders
Nizoral
Selsun Blue
Stieprox
T-Gel
Nioxin
Revivogen
Regenapure

Do you get rashes on any of the following sites?

Face
Behind the ears
On the ears
Eyelids
Neck
Back

Other:____

Have you experienced increased hair on:

Abdominal area
Naval
Face and or Jawline
Nipples
Chest, shoulders or upper back

Other;____

Have you noticed a deepening of your voice recently? Yes No

Please indicate if you take any of these supplements:

Vitamin D
Vitamin B12 or B Complex
Omega 3
Omega 6
Biotin
CoQ10
Silica
Viviscal
Priorin
Zinc
Nature's Bounty Hair and Nail
Probiotics

Have you used any anabolic steroids for body building, fitness training, etc? Yes No

Have you used any of the following in the past? Hormone Replacement Birth Control Pills Copper IUD

Platelet Rich Plasma (PRP) Treatment for Hair Loss

Platelet Rich Plasma (PRP) is an injection treatment that uses the components of a person's own blood to stimulate hair growth. Platelets are very small cells in your blood that are involved in the clotting process. When PRP is injected into the damaged area it causes a mild inflammation that triggers the healing cascade. As the platelets organize in the tissue they release a number of enzymes to promote healing and restoration of tissue. They have also been shown anecdotally to promote hair growth.

Method

A small quantity of blood (25cc-55cc) is drawn from the patient into a syringe. This is a relatively small amount compared to blood donation which removes approximately 500cc. The blood is spun in a special centrifuge (according to standard Harvest Techniques) to separate its components (Red Blood Cells, Platelet Rich Plasma, and Plasma). The platelet rich plasma is separated from the rest of the blood and then activated with a small amount of calcium to allow the release of growth factors from the platelets which in turn amplifies the healing process. Following the administration of local anesthesia (xylocaine), PRP is then injected directly into thinning areas of the scalp.

Treatment Schedule

- 1st Rx
- 2nd Rx at 6 weeks
- 3rd Rx at 3 months
- 4th Rx at 6 months
- Then every 6 months (depending on the response)

Indications

- Androgenetic hair loss (male and female pattern alopecia)
- Age $\geq$ 21 years

Relative Contraindications

- Acute and chronic infections
- Certain skin diseases (i.e. SLE, porphyria)
- Allergies to anesthetics (lidocaine, xylocaine)
- Cancer
- Chemotherapy
- Blood or bleeding disorders
- Anti-coagulation therapy
- Chronic liver disease
- Systemic use of corticosteroids within two weeks of the procedure
- Pregnant or breast feeding

Risks and Complications

- Pain or itching at the injection site
- Bleeding
- Bruising
- Swelling and/or infection
- Temporary pinkness/redness (flushing) of the skin
- Allergic reactions to the solution
- Injury to a nerve from the injection
- Nausea/vomiting
- Peri-operative dizziness or fainting

Use of Anesthetics Local anesthetics (xylocaine with epinephrine) may be used for your procedure if you are not allergic. Please initial if you have a problem with local anesthetics: ___ I am allergic ___ I am not sure ___ I am not allergic