Questionnaire

Today's Date: _____

Last Name: _____ First Name: _____

Age: _____ Birth Date ddmmyyyy: _____

Address: _____ City_____ Postal Code: _____

Email: _____ Day Phone: _____

Evening Phone: _____ Mobile Phone: _____

Occupation: _____

How Found CHTC: ___CHTC patient ___Family ___Friend ___Hair Stylist ___Physician ___Internet Search ___Global News Story
___Newstalk 1010 Ad ___Hair Transplant Network Forum ___Other: _____

Hair Loss

How long have you been losing hair? _____

How fast has your hair loss been in the last year? ___stopped ___slow ___gradual ___fast ___other_____

Is there anything unusual about your hair loss? _____

Who in your family has hair loss? _____

Who have you consulted? ___Family Doctor ___Dermatologist ___Hair Transplant Forum _____

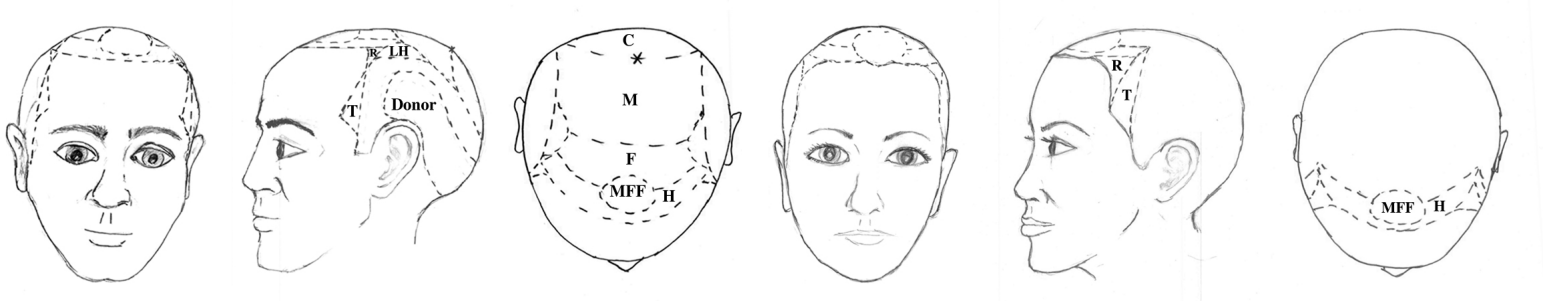
Hair Transplant Doctors _____

Have you tried? Rogaine/Minoxidil from _____to _____ Propecia/Proscar/Finasteride from _____to _____

Hair Transplants by _____ in _____

Other Treatments _____

Please rank your top priorities: ___hairline (H) ___recessions (R) ___midfrontal forelock (MFF) ___front (F) ___top/midscalp (M)
___sides (S) ___crown (C) ___temples (T) ___other _____



You can shade in the areas of concern.

What areas of hair loss don't bother you? _____

Is there a specific reason why you want more hair? (eg. Relationship, Job Change etc.)_____

How would having better hair help you the most? _____

At what decision-making stage are you? ___Not interested in hair transplants but want to diagnose cause and explore other options
___Gathering information and exploring all options, including hair transplantation
___Leaning towards hair transplantation but need more information
___Want a hair transplant but deciding where to have it

When do you plan to have your hair transplant? _____ What budget do you have in mind? _____

What questions do you most want answered today? _____

_____

_____

_____

_____

CANADIAN HAIR TRANSPLANT CENTRE

Last name:_____ First Name: _____

Medical

Family Doctor _____ Last Physical: _____ Height: _____ Weight: _____

Ongoing health concerns (eg. Diabetes, BP, Heart Disease, Cancer, Epilepsy, Infection): _____

_____

Daily Medications: _____

_____

Allergies: _____

Family History (Please describe major health concerns briefly)

Father _____

Mother _____

#____Brothers _____

#____Sisters _____

Other (Grandparents, Uncles, Aunts, Cousins, etc.) _____

Past Surgeries/ Anesthetics (Transplants, Tonsils, Appendix, Wisdom Teeth, Hernia, Gall Bladder etc.): _____

_____

How often and how long do you exercise? _____

Can you climb 2 flights of stairs without chest pain or shortness of breath? ___Yes ___No

How much do you smoke? _____

How much alcohol do you drink? _____

Please check all of the following that apply: ___None

___Bleeding or Clotting Problems: _____

___Trouble with surgeries or anesthetics: _____

___Fainting or Dizzy Spells: _____

___Heart, Circulation, or Blood Pressure Problems (Chest Pain, Rhythm problems etc.): _____

___Respiratory/Lung Diseases (eg. Asthma, Chronic Cough etc.): _____

___Neurologic Problems (eg. Strokes, Seizures, Bad Headaches etc.): _____

___Skin Problems (scarring, acne, rashes etc) _____

___Chronic Infections (Hepatitits, HIV, TB etc.): _____

___Psychological Problems (eg. Addictions, Depression, Anxiety etc.): _____

___Are you used to pain medications, sleeping pills, or anti-anxiety medications?; _____

___Endocrine Diseases (eg. Diabetes, Thyroid, Hormone etc.): _____

___Blood Disorders (eg. Anemia, Iron Deficiency etc.): _____

___Cancer: _____

___Nutrition or Significant Weight Changes: _____

___Gastrointestinal Problems (eg. Ulcer, Gastritis, Liver Disease etc.): _____

___Sexual Concerns (eg. Trying to conceive, erectile dysfunction, libido etc.): _____

___Urinary Problems (eg. Kidney Failure, Prostate Disease etc.): _____

For Women Only (Have you had …):

__Bad acne __Excessive Facial Hair..__Irregular Periods __Trouble getting pregnant __Ovarian Cysts __Rapid Weight Gain __Facial Seborrhea

Additional Notes:

_____

_____