Hair Regrowth Screening Form

BOLD RED items are hard contra-indication

Name: **Date:**

Address:

City: **St:** **ZIP:**

Home Phone: **Cell Phone:**

Email: **Referred by:**

Yes No Are you over 18 years of age?
Yes No Do you take aspirin or blood thinners regularly?
When did your hair start thinning?
Yes No Have you taken any mood altering drugs in the past 8 hours?
Yes No Do you have a history of cold sores, herpes or fever blisters?
Yes No Are you sensitive to Latex?
Yes No Have you had other hair regrowth treatments?
Yes No Do you have trouble healing?
Yes No **Are you currently undergoing radiation or chemotherapy?**
Yes No Are you allergic to any metals?
Yes No Are you currently taking anti-inflammatory medications or steroids?
Yes No Are you allergic to any anesthetics, (any of the "caines")?
Yes No Do you have a history of skin disease?
Yes No Do you have a history of skin sensitivity?
Yes No Are you currently taking vitamin A or E in any form?
Yes No **Are you pregnant or nursing?**
Yes No Have you ever been diagnosed with "Male Pattern Baldness"?

Please circle any that apply to you:

Heart Condition	Hepatitis	HIV	Cold Sores
Hyper Pigment	Smoker	Compromised Immunity	**Accutane in last 2 yrs**
Allergic to Steel	**Diabetes (uncontrolled)**	**Chronic Skin Disease**	**Hemophilia**