TrichoTest™

Personalizing alopecia treatment

questionnaire

Patient First Name: ..... Patient Last Name: .....

Date of Birth: ..... / ..... / ..... Height (in): ..... Weight (lb): .....

Collection Date: ..... / ..... / ..... Collection Time: ..... AM/PM ❑ Male ❑ Female

❑ American Indian/Native Alaskan ❑ Asian ❑ Ashkenazi Jewish ❑ African American
❑ Hawaiian/Pacific Islander ❑ Hispanic/Latino ❑ Caucasian ❑ Mixed Race ❑ Other

Patient Phone Number: ..... Patient Email: .....

Patient Address: .....

Provider Name: ..... Practice Name: .....

Provider Phone Number: ..... Provider Email: .....

*denotes Required field

PERSONAL ASPECTS

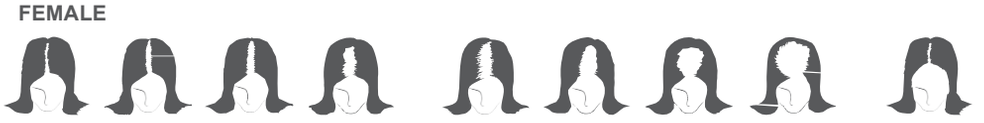
01. Type of Alopecia*

☐ Androgenic Alopecia ☐ Telogen Effluvium (seasonal) ☐ Alopecia Areata

02. Grade*

MALE

FEMALE



03. Direct family members suffering from alopecia and/or hair loss*

☐ None ☐ Parents ☐ Siblings ☐ Both

04. For how long has your hair been falling out?*

☐ More than a year ☐ Less than a year ☐ My hair doesn't fall out

05. Do you have hypersensitivity to caffeine?*

☐ Yes ☐ No

06. Hypersensitivity (Select all that apply)

☐ Minoxidil ☐ Latanoprost ☐ Prostaquinon ☐ Cetirizine
☐ 17-α Estradiol ☐ Finasteride ☐ Dutasteride ☐ Cyproterone
☐ Spironolactone ☐ Tretinoin

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07. Do you consume any of the following substances? (Select all that apply)

- ☐ Alcohol ☐ Tobacco ☐ Cannabis ☐ Cocaine
- ☐ LSD ☐ Benzodiazepines ☐ Barbiturates ☐ Amphetamines

08. Do you take any of the following medications? (Select all that apply)

- ☐ Antidepressants ☐ Contraceptives ☐ Corticoids
- ☐ Antihypertensive ☐ Anti-acne ☐ Estrogen Synthesis Inhibitors
- ☐ SADBE

09. Do you have any of these allergies or sensitivities? (Select all that apply)

- ☐ Pollen ☐ Mites ☐ Fungi ☐ Animal Hair ☐ Insect Bite
- ☐ NSAID ☐ Antibiotic ☐ Insulin ☐ Propylene Glycol Alcohol ☐ Penicillin

10. Do you have any of the following diseases? (Select all that apply)

- ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Diabetes ☐ Cushing Syndrome
- ☐ Hirsutism ☐ Endometriosis ☐ Hypertension ☐ Autoimmune Diseases
- ☐ Anemia ☐ Cancer ☐ SAHA (Seborrhoea, Acne, Hirsutism, Alopecia)
- ☐ Hypotension ☐ Benign Prostatic Hyperplasia ☐ Cardiovascular Diseases
- ☐ Estrogenic Hormonal Imbalance ☐ Polycystic Ovarian Syndrome (PCOS)

11. Cholesterol level?*

☐ High ☐ Normal ☐ Low

12. Level of hemoglobin?*

☐ High ☐ Normal ☐ Low

13. Level of hematocrit?*

☐ High ☐ Normal ☐ Low

14. Size of red blood cells?*

☐ High ☐ Normal ☐ Low

15. TSH level (thyroid)?*

☐ High ☐ Normal ☐ Low

16. T3 level?*

☐ High ☐ Normal ☐ Low

17. T4 level?*

☐ High ☐ Normal ☐ Low

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18. Do you use any of these hair products? (Select all that apply)

☐ Hair spray ☐ Gummies ☐ Hair gel ☐ Hair dryer ☐ Hair dyes ☐ Baseball cap

19. Hair length*

☐ Short ☐ Long

20. How much hair falls out?*

☐ A lot ☐ Little bit ☐ Nothing

21. Are you currently following a hypocaloric (low-calorie) diet?*

☐ Yes ☐ No

22. Do you take testosterone (anabolic) derivatives?

☐ Yes ☐ No

23. Are you pregnant?*

☐ Yes ☐ No ☐ N/A

24. Do you suffer stress?*

☐ Yes ☐ No

25. Last time you washed your hair*

☐ Less than 24 hours ago ☐ More than 24 hours ago

26. Do you have any of the following conditions on the scalp? (Select all that apply)

☐ Seborrhea ☐ Scales ☐ Scabs ☐ Irritations ☐ Psoriasis
☐ Seborrheic Dermatitis ☐ Dandruff ☐ Dermatitis

27. Do you have alopecic plaques?*

☐ Yes ☐ No

28. Have you recently made a change of residence?*

☐ Yes ☐ No

29. Do you have depression?

☐ Yes ☐ No

30. Do you rest enough?

☐ Yes ☐ No

questionnaire

31. Have you recently had a child?

☐ Yes ☐ No

32. Do you have post-surgical stress?

☐ Yes ☐ No

33. Do you have irregular menstruations?*

☐ Yes ☐ No ☐ N/A

34. Do you have a heavy menstrual cycle?*

☐ Yes ☐ No ☐ N/A

35. Is your work in contact with toxic / polluting materials?

☐ Yes ☐ No

36. Do you have any of these eating disorders?

☐ Bulimia ☐ Vigorexia ☐ Anorexia

thank you!