THE SKIN WELLNESS CENTER

Patient Name _____ Date _____ Patient # _____

When did you last shampoo? _____ Today _____ Three days ago

_____ One day ago _____ Four days ago

_____ Two days ago _____ Other _____

Please answer yes or no to each question. If the question does not apply to your sex, write N/A (meaning not applicable).

Is the hair coming out by the roots?	Yes / No
Is the hair breaking off?	Yes / No
Do you notice excess loss in your comb, on your shoulders, in the sink or on your pillow?	Yes / No
Is your hair becoming thinner?	Yes / No
Has your barber/beautician noticed thinning?	Yes / No
Has your family noticed thinning?	Yes / No
Do you have any totally bald spots?	Yes / No
Is the loss slowing down?	Yes / No
Is the loss getting worse?	Yes / No
Have you ever counted the number of hairs you lose daily? How many on average? _____	Yes / No
Do you color your hair?	Yes / No
Do you bleach your hair?	Yes / No
Do you straighten your hair?	Yes / No
Do you have a permanent?	Yes / No
Do you shampoo daily?	Yes / No
Name of shampoo	
Do you use conditioner?	Yes / No
Name of conditioner	
Do you use a blow dryer?	Yes / No
Do you hot comb your hair?	Yes / No
Is your scalp itchy or flaky?	Yes / No
Do you have dandruff?	Yes / No
Do you have psoriasis?	Yes / No
Do you wear a wig or hairpiece?	Yes / No
Is your father's hair thinning?	Yes / No
Is your father bald?	Yes / No
Is your mother's hair thinning?	Yes / No

Is your brother's hair thinning?	Yes / No
Is your sister's hair thinning?	Yes / No
Are your menstrual periods regular?	Yes / No
Have you noticed increased hair on your abdomen?	Yes / No
Have you noticed increased hair on your breasts?	Yes / No
Has any other body hair increased? If yes, where?	Yes / No
Do you have acne?	Yes / No

In the past six months to 1 year, have any of the following events happened to you?

Had a baby?	Yes / No
Started an oral contraceptive (the pill)?	Yes / No
Stopped an oral contraceptive (the pill)?	Yes / No
Stopped hormone supplements (Premarin)?	Yes / No
Gone through menopause?	Yes / No
Had a fever of 103-104?	Yes / No
Had the flu?	Yes / No
Been hospitalized?	Yes / No
Had a major surgery?	Yes / No
Had general anesthetic?	Yes / No
Been on a crash diet?	Yes / No
Lost more than 2 pounds per week?	Yes / No
Are you a vegetarian? If yes, what is your protein source?	Yes / No
Have you had a major stress during this time? If yes, what type?	Yes / No

In regards to your general health:

Do you have anorexia nervosa?	Yes / No
Do you have a thyroid disorder?	Yes / No
Overactive thyroid?	Yes / No
Underactive thyroid?	Yes / No
Do you take thyroid medication?	Yes / No
If yes, name of medication: Dosage:	
Are you constipated?	Yes / No
Have you gained weight?	Yes / No
Have you lost weight?	Yes / No
Has your voice changed?	Yes / No
Are you anemic?	Yes / No
Are your menstrual periods heavy?	Yes / No
Do you have a stomach or duodenal ulcer?	Yes / No

Do you have heart disease?	Yes / No
Do you have high blood pressure?	Yes / No
Do you take vitamins?	Yes / No
If yes, what is the name of the vitamin?	
Is there a vitamin A in this pill?	Yes / No
If yes, how much?	
Do you take a separate vitamin A tablet?	Yes / No
Do you see any other doctors for any medical illnesses not mentioned in this questionnaire?	

Do you take any of the following medications on a regular basis?

Allopurinal (Zyloprim)	Yes / No	Amphetamines	Yes / No
Phenytoin (Dilantin)	Yes / No	Beta blockers	Yes / No
Aspirin	Yes / No	Azulfidine	Yes / No
Carbamazepine (Tegretol)	Yes / No	Gentamicin	Yes / No
Coumadin	Yes / No	Iodines	Yes / No
Heparin	Yes / No	Levodopa	Yes / No
Isotretinoin	Yes / No	Penicillamine	Yes / No
Lithium	Yes / No	Triparanol	Yes / No
Birth control pills	Yes / No	Gold shots	Yes / No
Vitamin A	Yes / No	Propylthiouracil-PTU	Yes / No
Multivitamins	Yes / No	Methimazoile	Yes / No
Colchicines	Yes / No	Atromid-S	Yes / No
Anticancer drugs	Yes / No	Choloxin	Yes / No

Do you take any other medications not listed here? Please list name and dosage.

_____

_____

_____

_____ _____ _____

Signature of Patient or Patient's Representative Relation to Patient Date

Advance Notice for Waiver of Liability
Commercial Insurance

Patient Name _____ Date_____ Patient # _____

Insurance: _____

Physician Notice:

Most insurance companies will only pay for services that it determines to be "reasonable and necessary." If your insurance determines that hair loss is not reasonable and necessary," the insurance will deny payment for that service. I believe that, in your case, your insurance is likely to deny payment for:

Service: *hair loss evaluation and treatment*

Beneficiary Agreement:

"I have been notified by my physician that he or she believes that, in my case, my insurance is likely to deny payment for services identified above, for the reasons stated. If my insurance denies payment, I agree to be personally and fully responsible for payment."

_____ _____ _____

Signature of Patient or Patient's Representative Relation to Patient Date

Possible Reasons for Denial

1. Most insurance companies usually do not pay for removal/treatment of benign, asymptomatic lesions.
2. Most insurance companies usually do not pay for cosmetic procedures.
3. Most insurance companies usually do not pay for this many visits or treatments.
4. Most insurance companies usually do not pay for this type of equipment.
5. Most insurance companies usually do not pay for this lab test.
6. Most insurance companies usually do not pay for this treatment because it has not yet been proven effective.
7. Most insurance companies usually do not pay for treatment of hair loss because they consider it to be cosmetic.