PAI MEDICAL GROUP®
Trust. Care. Confidence.

# Patient Questionnaire

Name _____ Male ◯ Female ◯

Today's Date _____

Address _____ City/Town _____

Province sf _____ Postal Code _____

Home Phone _____ Work Phone _____

Mobile Phone _____

Date of Birth _____ Age ____ Marital Status _____

Occupation _____ Email _____

How did you hear about PAI Medical Group? _____

_____

Have you seen a physician regarding your hair loss? Yes ◯ No ◯

Have you had any transplant procedures done in the past? Yes ◯ No ◯

If yes, when and how many sessions/number of grafts were done?

_____

How old were you when you first noticed your hair loss? _____

Please indicate where hair loss or thinning appears in your family:

(indicate levels where possible - refer to chart below)

| | Father/Mother | Grandfather | Uncles | Great Grandfather |
|---|---|---|---|---|
| Father's Side | | | | |
| Mother's Side | | | | |

Siblings _____ Other _____

Which pattern is most predominant in your family? (Refer to charts at right) _____

Which pattern do you feel better represents your hair loss? _____

Do you have any skin allergies?

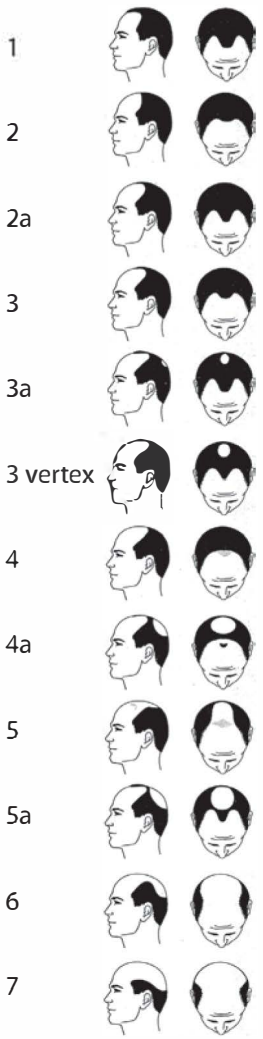
Chronic psoriasis? Yes ◯ No ◯

Did you tell anyone you were coming here today? Yes ◯ No ◯

If yes, who? _____

Have you considered other alternatives for your thinning hair? Yes ◯ No ◯

If yes, please describe _____





What research have you done regarding your hair loss?

☐ Seen a physician ☐ Internet ☐ Library ☐ Other ☐ _____

What have you learned from your research? _____

What is the main reason you would like to have your hair back? _____

What are your hair loss goals? ☐ Slow down hair loss ☐ Fill in thinning areas

Other (Please describe) _____

What are your expectations for getting your hair back?

☐ Get my hair back gradually over time ☐ Prevent future loss

☐ Get a full head of hair as soon as possible ☐ Other _____

What concerns, if any, would you have about this procedure? _____

Is there a date/special occasion that you would like to get your hair back by? _____

Please indicate which areas your hair loss affect you: (Please check)

| | | |
|---|---|---|
| ☐ When I meet new people | ☐ When I see pictures/videos | ☐ On a windy day |
| ☐ When others make comments | ☐ When I have to wear a hat | ☐ My self-esteem |
| ☐ At the beach or swimming | ☐ My overall appearance | ☐ In my social life |
| ☐ When I get dressed up | ☐ When I see old friends | ☐ When I'm at work |

Please rank the concerns that apply to your feelings about hair restoration surgery in order of importance to you (1 = your greatest concern; 10 = your least concern)

| | | |
|---|---|---|
| ____ Camouflaging after surgery | ____ Affordability | ____ Discomfort |
| ____ Final result | ____ Time off work | ____ Other |

**CLICK & SUBMIT YOUR COMPLETED FORM NOW TO PAI VIA EMAIL (Please be patient, this may take a minute!)**

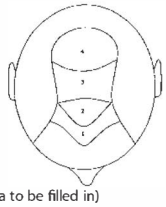
Below for office use only

Patient's expectations _____ Patient's donor density _____

Patient's hair color _____ Patient's hair texture _____

Session size recommended _____ Number of sessions recommended _____

Concerns _____



(Indicate area to be filled in)

Notes _____ _____

_____ _____

_____ _____

Specialist _____ _____

Referred By _____ Date ____ _____