MANDAL PLASTIC SURGERY CENTER, P.A. (O: 5/31/25)

Male Hair Loss Questionnaire

1. If 10 is the highest priority and 0 the least, how important is it to you to stop your hair loss and regain your hair?
Only circle one number: 0 1 2 3 4 5 6 7 8 9 10

2. Have you ever used any medications, supplements, or topical hair treatments to improve your hair loss? □ No □ Yes
List ALL medication(s), supplements, topical treatments used now or in past.
_____
_____

3. Have you ever had any medical condition that affects your scalp? □ No □ Yes
Please explain:_____

4. Have you ever had any surgery on your scalp, including hair transplants? □ No □ Yes
Please explain:_____

5. Have you ever worn a hairpiece, such as a wig or toupee? □ No □ Yes
Please explain:_____

6. At what age did you first notice your hair loss?
□ Under 20 □ 21-25 □ 26-30 □ 31-35 □ 36-40 □ 41-45 □ 46-50 □ 51-60 □ 60-70 □ > 70 □ Special Circumstances (Explain): _____

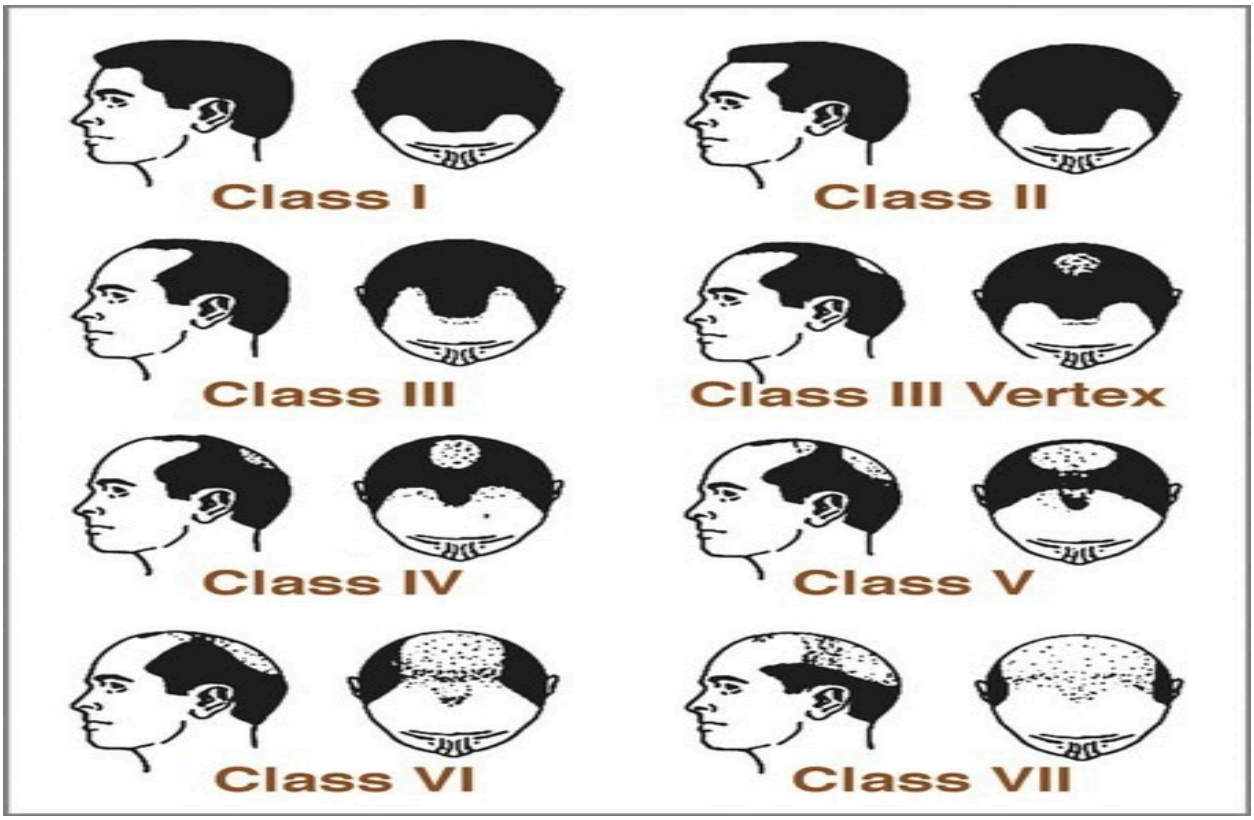
7. How would you describe your hair loss? □ Receding □ Thinning □ Balding

8. In what areas would you describe your hair loss? □ Hairline □ Top □ Back □ All over

Check all biological family members with extent hair of hair loss:

Relationship:	None	Hairline	Top	Back	All Over
Brother	□	□	□	□	□
Father	□	□	□	□	□
Paternal Grandfather	□	□	□	□	□
Maternal Grandfather	□	□	□	□	□

9. Please circle the image that best describes your hair loss today:



I have thoroughly answered all questions accurately and truthfully. I agree to notify Dr. Mandal's office, in writing, of any changes in my condition and/or above answers within 48 hours of becoming aware of them as well as prior to receiving any treatments.

Patient name _____

Print name _____ Date: ____/____/____