



# REGENIX HAIR RETENTION CLINIC

## QUESTIONNAIRE

NAME \_\_\_\_\_ DATE: DAY \_\_\_\_\_ MONTH \_\_\_\_\_ YEAR \_\_\_\_\_  
HOW DID YOU HEAR ABOUT REGENIX \_\_\_\_\_ EMAIL \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
PHONE: RES ( ) \_\_\_\_\_ BUS. ( ) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ GENDER \_\_\_\_\_  
OCCUPATION \_\_\_\_\_ ETHNIC ORIGIN \_\_\_\_\_

### REGENIX HEALTH & HYGIENE QUESTIONNAIRE GUIDELINES

*If you ordered the Regenix Jump Start Kit, please complete this questionnaire before starting the treatment. It will take approximately 3 weeks to receive your results from this analysis. You will receive a detailed letter explaining any problems that were identified along with microphotographs\*\* of your hair samples.*

**\*\* The number of microphotographs depends on the number of usable hair samples received.**

**Step One** - Fill out the questionnaire

When filling out the questionnaire, please **PRINT** clearly. Furthermore, be as thorough and accurate as possible.

**Step Two** -Take the Loose Hair Samples

1. Locate an area on your scalp that corresponds with an area on the diagram.
2. Grasp a tuft of hair close to the scalp with your thumb and middle finger.
3. Gently squeeze the hairs while simultaneously pulling the hair upwards.
  - a. Ideally 2 to 3 loose hairs should be released from the scalp. In order to perform a more thorough analysis, 4 to 5 hairs should be removed from each of the designated areas and adhered to the diagram.
  - b. The bulb must be visible. It appears as a small white ball on the end of the hair that came from the scalp.
4. Using tape, affix your samples to the corresponding areas on the diagram. **DO NOT** place the tape over the bulb.
5. Send the form with your samples attached to the following address:

REGENIX HAIR RESEARCH CLINIC  
Cedars –Sinai Medical Office Towers  
8631 West Third Street, Suite 420E  
Los Angeles, CA 90048



**FOLLICULAR ANALYSIS QUESTIONNAIRE**

HOW LONG DOES IT TAKE YOUR SCALP TO GET OILY AFTER YOU SHAMPOO? \_\_\_\_\_ HOURS  
WHAT COLOR IS YOUR HAIR NATURALLY? \_\_\_\_\_  
DO YOU FEEL YOUR SCALP IS LOOSE AND PLIANT \_\_\_\_\_ TIGHT AND CONSTRICTED \_\_\_\_\_  
DO YOU EXPERIENCE: DANDRUFF \_\_\_\_\_ FLAKING \_\_\_\_\_ ITCHING \_\_\_\_\_ BREAKAGE \_\_\_\_\_  
APPROXIMATE DATE HAIR LOSS WAS FIRST NOTICED \_\_\_\_\_  
FAMILY HISTORY OF HAIR LOSS OR BALDNESS IF APPLICABLE:  
MOTHER'S SIDE \_\_\_\_\_ FATHER'S SIDE \_\_\_\_\_

**HEALTH HISTORY / ENVIRONMENTAL FACTORS**

DATE OF LAST COMPLETE PHYSICAL EXAMINATION \_\_\_\_\_  
WERE ANY PROBLEMS DIAGNOSED? YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES, DESCRIBE \_\_\_\_\_

DO YOU EVER HAVE SKIN PROBLEMS? Circle  
ACNE RASHES OILY DRY OTHERS: \_\_\_\_\_  
ARE YOU TAKING ANY MEDICATION PRESENTLY YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, PLEASE LIST \_\_\_\_\_

PLEASE LIST ANY MEDICATIONS YOU HAVE TAKEN IN THE PAST \_\_\_\_\_

DO YOU SMOKE CIGARETTES YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, HOW MANY PER DAY \_\_\_\_\_  
DO YOU TAKE ANY VITAMIN, MINERAL, OR OTHER FOOD SUPPLEMENTS ON A REGULAR BASIS? YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES, PLEASE LIST WHAT THESE ARE AND HOW LONG YOU'VE TAKEN THEM: \_\_\_\_\_

**HYGIENE / COSMETIC FACTORS**

HOW OFTEN DO YOU SHAMPOO? \_\_\_\_\_ (Times per week)  
WHAT BRAND OF SHAMPOO DO YOU CURRENTLY USE \_\_\_\_\_  
DO YOU USE A CONDITIONER? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, WHAT BRAND \_\_\_\_\_  
DO YOU USE A HAIR DRYER? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, HOW OFTEN \_\_\_\_\_  
HAVE YOU EVER COLORED YOUR HAIR? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, HOW OFTEN \_\_\_\_\_  
HAVE YOU EVER PERMED? YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES, HOW OFTEN \_\_\_\_\_

HAVE YOU TRIED ANYTHING FOR YOUR PROBLEMS? YES \_\_\_\_\_ NO \_\_\_\_\_  
PROPECIA/PROSCAR: Began Use: \_\_\_\_\_ Ended: \_\_\_\_\_ - Still Using - Any positive changes? YES \_\_\_\_\_ NO \_\_\_\_\_  
TAR-BASED SHAMPOOS: Began Use: \_\_\_\_\_ Ended: \_\_\_\_\_ - Still Using - Any positive changes? YES \_\_\_\_\_ NO \_\_\_\_\_  
MINOXIDIL/ROGAINE: Began Use: \_\_\_\_\_ Ended: \_\_\_\_\_ - Still Using - Any positive changes? YES \_\_\_\_\_ NO \_\_\_\_\_  
HORMONES: Began Use: \_\_\_\_\_ Ended: \_\_\_\_\_ - Still Using - Any positive changes? YES \_\_\_\_\_ NO \_\_\_\_\_  
OTHER: \_\_\_\_\_ Began Use: \_\_\_\_\_ Ended: \_\_\_\_\_ - Still Using - Any positive changes? YES \_\_\_\_\_ NO \_\_\_\_\_

**THE INFORMATION I HAVE FILLED OUT IS CORRECT TO THE BEST OF MY ABILITY AND I UNDERSTAND THERE IS NO OBLIGATION.**

DATE \_\_\_\_\_ SIGNED \_\_\_\_\_

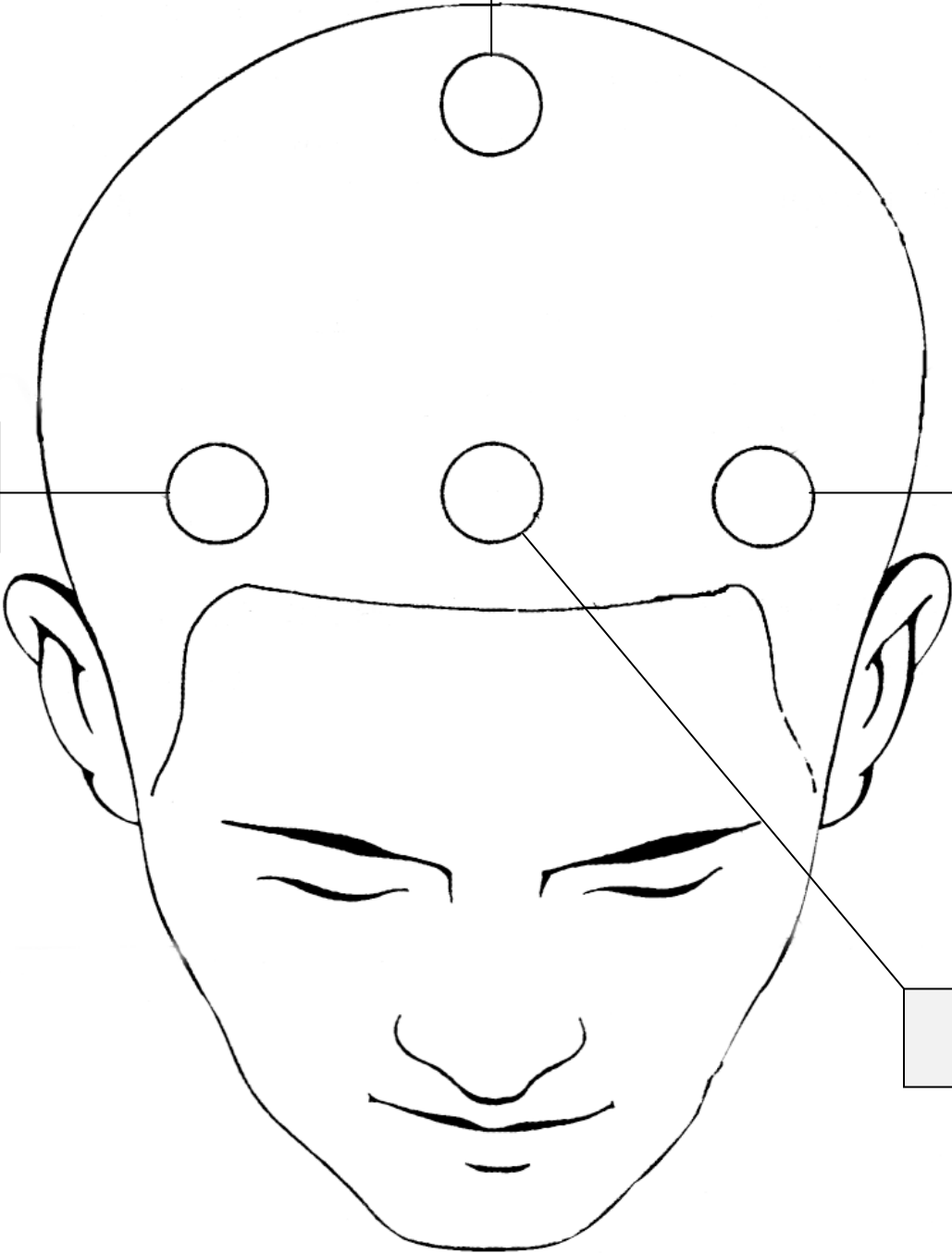
HAIR SAMPLE CHART

Crown

Right  
Temporal

Left  
Temporal

Vertex



Name: