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# CONSULTATION CARD

Ref. No: ..................
Date: ..................

Consultant Name: ___________________

## (A) PATIENT INFORMATION

Name ..........................................................

Occupation ..........................................................

Address ..........................................................

Postcode .................................... State .................................... Country ....................................

Contact No. Mobile .................................... Office .................................... Home ....................................

Email ....................................

Preferred Language ..........................................................

How do you hear about UNGEX?

☐Newspaper _____________
☐Road show _____________
☐Others _____________
☐Internet _____________
☐Friend, Relative _____________

## (B) HAIR / SCALP'S CONDITION

1. How do you feel about the condition of your hair / scalp?
   ☐Healthy
   ☐Slow growing hair
   ☐Dry scalp
   ☐Oily scalp
   ☐Brittle / dry hair
   ☐Alopecia Aerate
   ☐Post-natal hair loss
   ☐Other ___________
   ☐Hair Loss
   ☐Dandruff
   ☐Thinning Hair
   ☐Itchy
   ☐Damaged
   ☐Split ends
   ☐Grey Hair

2. Problem area that concern you the most?
   ☐Whole head ☐Sides
   ☐ Hair line ☐Back
   ☐Crown area

3. How often do you wash your hair?
   ☐Daily ☐4 times a week
   ☐2-3 times a week ☐1 times a week

4. Type of shampoo :_____________

   Brand ________________________

5. Approximately how many strands of hair do you lose a day?
   ☐0-10 ☐11-30 ☐31-50 ☐50+ ☐not sure

6. How long have you been suffering from this condition?
   _______ years ________ months

7. Do any of your family members suffer from hair loss?
   ________________________________________

8. Have you ever, or are you currently using any hair growth products?
   ☐ Yes ( Brand ___________ ) ☐No

9. Previously / currently under hair treatment
   ☐Yes ( Brand___________ ) ☐No

10. Chemical service done in the past 3 months?
    ☐ No ☐Colored
    ☐Perm ☐Rebounding

11. Do you use any styling tools?
    ☐No ☐Hair Dryer
    ☐Brush
    ☐Curl

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## (C) LIFE STYLE

1. What is your stress level?
☐Low ☐High
☐Moderate

2. Your working environment?
☐Indoor ☐Outdoor
☐Both

3. Do you smoke?
☐Everyday ☐Occasionally
☐Often ☐Never

4. Do you consume alcohol?
☐Everyday ☐Occasionally
☐Often ☐Never

5. How is your sleeping hours?
From ____to____, total ____hours

6. Are you on diet?
☐Yes ☐No

7. Are you a vegetarian?
☐Yes ☐No

8. Do you like to eat?
☐Fried food ☐Sweet food
☐Spicy food ☐Snack

## (D) MEDICAL HISTORY

☐Pacemaker
☐Epilepsy
☐Pregnancy
☐High blood pressure
☐Low blood pressure
☐Menstrual irregularities
☐Food supplement ____________________
☐On medication ________________
☐Other (please specify) ____________________

☐Contraceptive
☐Diabetes
☐Skin sensitive / Disease
☐Digestion problem
☐Menopause
☐Kidney problem

☐Cancer
☐AIDS
☐Digestion problem
☐Insomnia
☐Thyroid problem
☐Liver problem

I HEREBY CERTIFY THAT THE INFORMATION GIVEN BY ME IN THIS DOCUMENT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature ________________________

Date ________________________