Metrolina Dermatology and Skin Surgery Specialist

NAME:_____ **DOB:** _____

Hair Loss Questionnaire

If you have an appointment to be seen for hair loss, please fill out the form and bring with you to your appointment. For some questions you will need to mark the YES or NO box at the right. For other questions, simply write your answers in the spaces provided.

Background of hair loss:

1. When did you FIRST notice that you were losing your hair? _____
   What did you notice at that time? ☐ hair coming out / shedding ☐hair looked thinner on scalp ☐ other
   _____

2. Have you recently noticed that your hair loss was worsening ☐ Yes ☐ No
   If yes, when did you being to notice it was worsening? _____
   What makes you think it is worsening? _____

3. Is your hair being lost:
   ☐in patches ☐ diffusely (evenly all over the scalp) ☐ mostly over the top of the scalp
   ☐ other _____

4. Do you have symptoms on the scalp (ex itching, burning, pain, dandruff)? ☐ Yes ☐ No
   If yes, indicate which symptom(s) has occurred (please check all the apply):
   ☐ itching ☐tenderness ☐pain ☐burning ☐ dandruff ☐other_____

   Where on the scalp do the symptoms occur?
   ☐ the top ☐the sides ☐the back ☐the temples ☐other_____

5. Do you have unwanted or excessive hair growth on your body? ☐ Yes ☐ No
   Where is the unwanted/excessive hair growth located? _____
   _____

6. Do you have hair loss anywhere else on your body? ☐ Yes ☐ No
   Where (other than scalp) is the hair loss located? _____

7. Do you have any abnormal fingernails or toenails? ☐ Yes ☐ No
   If yes, please describe the problem: _____

8. Do you have a family history of hair loss? If yes, please explain with which family member(s) and how much hair loss: _____
   _____
   _____

Past Medical History:

9. Have you been pregnant at any time before or during the hair loss? ☐ Yes ☐ No
   If yes, when did the pregnancy end? _____

10. Have you had any serious illnesses at any time before or after the hair loss? ☐ Yes ☐ No
    If yes, please describe the illness and state when it occurred
    _____
    _____

11. Have you been hospitalized at any time before or during the hair loss? ☐ Yes ☐ No
    If yes, why were you hospitalized and when did you leave the hospital? _____
    _____

12. Have you been under a severe amount of stress at any time before or during the hair loss?
    ☐ Yes ☐ No If yes, when did it start/end: _____

13. Are you menopausal? ☐ Yes ☐ No
    If you are menopausal, when did menopause occur? _____
    If you are menopausal, were your periods (menses) regular prior to menopause? ☐ Yes ☐ No

14. If you are not menopausal, do you get your menstrual period every month? ☐ Yes ☐ No
    If yes, how often does your period come? Every_____ days

15. Have you ever needed to take birth control pills to make your periods regular? ☐ Yes ☐ No

16. Have you had a biopsy of your scalp to evaluate your hair loss problems? ☐ Yes ☐ No

17. Have you had blood tests done to evaluate your hair loss problem? ☐ Yes ☐ No
    What tests were done and results? _____
    _____

18. Have your hormones ever been checked to evaluate your hair loss problem? ☐ Yes ☐ No
    If yes, when? _____
    What was the result? _____

19. Have you ever been told by a doctor that you have a thyroid condition? ☐ Yes ☐ No

20. Have you ever been treated with thyroid hormone? ☐ Yes ☐ No
    When? _____

21. Have you ever been told by a doctor that you have a low iron level? ☐ Yes ☐ No
    When? _____

22. Do you (or a family member) have any autoimmune diseases? ☐ Yes ☐ No

Check all that apply:

Lupus	*☐ self*	*☐family member (_____)*
Rheumatoid Arthritis	*☐ self*	*☐family member (_____)*
Celiac disease	*☐ self*	*☐family member (_____)*
Type 1 diabetes	*☐ self*	*☐family member (_____)*
Sjogrens disease	*☐ self*	*☐family member (_____)*
Vitiligo	*☐ self*	*☐family member (_____)*
Other (_____)	*☐ self*	*☐family member (_____)*

Diet and Medication History:

23. Have you started any special diets at any time before or during the hair loss? ☐ Yes ☐ No

24. Are you a vegetarian? ☐ Yes ☐ No

25. Please list the names of all the medications you are currently taking in the space below.
Check the ones you were taking when you noticed your hair falling out

☐_____

☐_____

☐_____

☐_____

26. Please list any additional medications that you were taking when your hair began to fall out that you are no longer taking:

_____

_____

_____

_____

27. Please list any vitamins or natural products that you are taking:

_____

_____

_____

_____

Hair care Practices:

28. How often do you wash/shampoo your hair? every_____days

29. How often if your hair chemically processed or straightened (relaxers, Japanese straightening, other)?
☐Never ☐Once a week ☐Once every 2-3 weeks ☐Once every 1-2 months ☐ few times/year

30. How often is your hair heat processed or straightened (blow-drying/flat ironing, curling iron)?
☐Never ☐Once a week ☐Once every 2-3 weeks ☐Once every 1-2 months ☐ few times/year

31. How often is your hair dyed, highlighted or otherwise color treated?
☐Never ☐Once a week ☐Once every 2-3 weeks ☐Once every 1-2 months ☐ few times/year

32. Please check all hair styling practices that you have done in the past
☐braiding ☐weaves ☐tight hairstyles (ex. ponytails) ☐other_____

33. Please list all the prescriptions and non-prescription treatments that you have tried for your hair loss condition:

Treatment	When was it tried?	For how long?	Did it help?

34. What do you think is the cause of your hair loss?
_____
_____
_____
_____

35. Is there any other important information you would like to share regarding your hair loss?
_____
_____
_____
_____