

HAIR LOSS QUESTIONNAIRE

Name: _____ DOB: _____

Race: _____ Height: _____ Weight: _____

1. When did you last have a normal head of hair? _____

2. Was onset of hair loss sudden or gradual? _____

3. Is your hair coming out "by the roots" or is it breaking off? _____
 (Please shade in areas of location of hair loss on the map to the right.)

4. Is your hair thinning or is it shedding? _____

5. How often do you wash your hair? _____

6. What hair products do you use? _____

7. Do you use hot rollers, ponytails, braids, twists, locks, extensions, or weaves? _____ How long? _____ How often? _____
 If you have a weave, is it sewn in or glued? _____

8. Do you use hot combs, press and curl, curling irons or otherwise apply direct heat to your hair? _____

9. What type of hair chemicals do you use for your hair? _____

Hair dye? _____ Name: _____

Relaxer? _____ Name: _____

Is it a relaxer that contains lye? _____ Do you have a permanent wave? _____

Name: _____ How long? _____ How often? _____

10. Does your scalp itch? Little Moderate A lot (Circle)

11. Do you get sores in your scalp? Yes No

12. Do you have Seborrheic Dermatitis? Yes No Psoriasis? Yes No

13. What medications are you allergic to? _____

14. What medications do you take? _____

Do you use herbs or supplements? Yes No

Name: _____

How long have you been taking: _____

15. If you are on birth control pills, which one? _____

Have you recently started? _____ When? _____

Or stopped your birth control pills? _____ When? _____

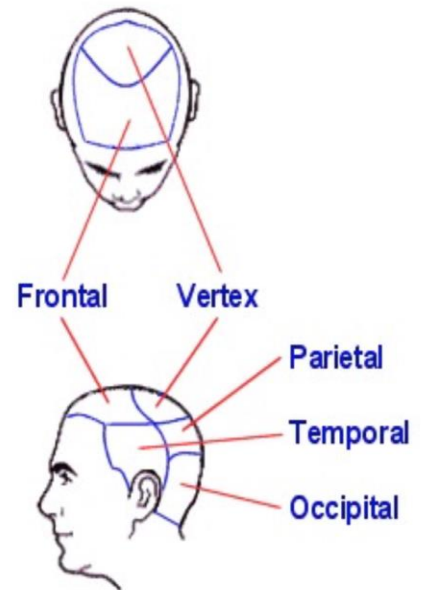
16. Are you on any other type of hormone treatment? _____

Which one? _____ How long? _____

Or stopped? _____ When? _____

17. If applicable, are your menstrual periods regular? _____ Normal flow? _____

If not, what is happening? _____ How long? _____



18. Have you gone through menopause? _____ Age? _____

19. Are you on any type of weight loss diet? _____

Are you on a low protein diet? _____

Are you a vegetarian (type)? _____

20. Any hair loss in men in your family? _____ Baldness? _____

Any hair loss in women in your family? _____ How thin? _____

Any family history of thyroid disease, anemia, or lupus? _____

21. What medical problems do you have? _____

22. Do you have?

- | | | |
|-----------------------------|------------------------------|-----------------------------|
| a. Severe headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Double vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Excess facial hair | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Excess body hair | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Cystic Acne | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Discharge from breast | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Deepening of voice | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Enlargement of clitoris | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Polycystic ovary disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

23. Have you had in the last 3-12 months?

- | | | |
|--|------------------------------|-----------------------------|
| a. High fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Childbirth | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Severe infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| d. Flare of chronic illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| e. Major surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| f. Over or under active thyroid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| g. Low protein diet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| h. Low iron in blood | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| i. Severe psychological stress | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| j. Start or stop birth control pills | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| k. Start or stop hormone treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| l. Start or stop beta blocker medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

24. Do you see a rash in your scalp or on your face? _____

If yes, please describe. _____

25. Treatments previously tried? (Rogaine, Vitamins, Shampoos, etc.) _____

26. HAVE YOU HAD LAB WORK DONE RECENTLY? Yes No **If yes, please either bring those results with you or have your doctor fax them to us at 315-701-0075**