HAIR LOSS QUESTIONNAIRE

What best describes your type of hair loss? (Check all that apply)

- □ Diffuse shedding: defined as having excessive numbers of hairs falling out daily
- □ Diffuse thinning: defined as having less hair to cover your scalp, with or without excessive hairs lost each day
- □ Hair loss in patches: defined as having round or irregular areas of total hair loss, scalp or other hair
- □ Patterned hair loss: defined as male pattern baldness

Please check yes or no for the following questions:

Yes  No
- □     □ Are your hairs breaking off?
- □     □ Are you hairs coming out with the root attached (white “bulb” at the end)?
- □     □ Any scalp tenderness?
- □     □ Itchy scalp?
- □     □ Sensitivity on scalp?
- □     □ Creepy-crawly sensation on scalp?
- □     □ Do you feel like you have been shedding excessive numbers of hair? (i.e. with grooming, brushing, in the shower or tub with shampooing, on pillow) If yes, please describe: ____________________________
- □     □ Other: ____________________________

Approximately how long have you noticed hair loss, thinning or shedding? ____________________________

Are you losing hair in any other areas other than your scalp? (i.e. eyebrows, sideburns, body hair, pubic hair)

________________________________________

FAMILY HISTORY (Include parents, siblings, children, grandparents, aunts and uncles)

Yes  No
- □     □ Is there a family history of males with male pattern baldness or thinning:
  If yes, then who? ____________________________
- □     □ Is there a family history of females with thinning hair over the top of the scalp?
  If yes, then who? ____________________________
## MEDICAL HISTORY

**Yes No**

- ☐ ☐ Any history of childbirth?
  - If yes, please specify MONTH/YEAR: __________

- ☐ ☐ Do you feel like you eat a well-rounded diet?

- ☐ ☐ Do you eat a sufficient amount of protein?

- ☐ ☐ Do you eat plentiful fresh fruits and veggies?

- ☐ ☐ Any recent weight loss?

- ☐ ☐ Any history of crash dieting?

History of **recent** surgery (related to the timing of hair loss):

  - Type of surgery: _____________________________________________________________
  - Date of surgery: ___________________________________________________________________

Recent illnesses or hospitalizations: __________________________________________________

All current medications, including over-the-counter medications, vitamins, holistic or herbal medications; duration of use, and any recent dose adjustments:

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<th>Dose</th>
<th>Duration of Use</th>
<th>Any recent dose adjustments</th>
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**Please Answer the Following Questions:**

**Yes No**

- ☐ ☐ Any personal history of thyroid disease? If yes, please specify: ______________________________________________________

- ☐ ☐ Any family history of thyroid disease? If yes, please specify: ______________________________________________________

- ☐ ☐ Any personal history of autoimmune disease?
  - If yes, please specify: ______________________________________________________

- ☐ ☐ Any family history of autoimmune disease?
  - If yes, please specify: ______________________________________________________

- ☐ ☐ Any previous treatments tried for hair loss?
  - If yes, please specify: ______________________________________________________

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HAIR PRACTICES

Yes  No

☐  ☐ Do you color or chemically treat your hair?
   If yes, please specify what types of treatments: ________________________________
   How often? ______________________

☐  ☐ Do you use heat treatments on your hair (including blow drying, flat iron, curling iron, etc.)
   If yes, please specify what types of treatments: ________________________________
   How often? ______________________

☐  ☐ Do you wear any hair pieces? (wigs, weave, extensions, toupee, clip-ons, wiglets)

STRESSORS

Yes  No

☐  ☐ Do you have any significant stressors?

☐  ☐ Life Stress?

☐  ☐ School Stress?

☐  ☐ Job Stress?

☐  ☐ Economic/financial stress?

☐  ☐ Moving or recent move?

☐  ☐ Marriage/death/divorce/living situation/serving as a caretaker

☐  ☐ Other stress? If yes, please specify: ________________________________