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Hair loss checklist

1. Hair loss patient history from received and completed
2. Complete the attached medical release form: include all doctors that have checked lab work, performed biopsy or evaluated hair loss. If you do not want to complete the request, you can bring with you recent (last 6 months) blood work, any prior (scalp) biopsy report or doctors notes to the visit. If you do not have any of these, anticipate lab work and/or a biopsy at DTLA Derm.
3. Picture of your hair when it was not thinning.
4. Do not shampoo hair for 1-2 days before your visit.
5. Do not comb or brush your hair the morning of your visit.
6. Do not wear nail polish.
7. Do not bring a bag of hair. We will examine and pluck hair during your visit.
8. We take hair loss very seriously due to the large impact it has on a patient's quality of life. We, therefore, devote a special time during the week for patients with this problem enabling more time, attention and detail to be given for this condition. As part of this, you need to be prepared for your visit. Your visit will only be focused on this condition. Hair loss appointments will not include skin checks, acne evaluation, cosmetics, etc.

Rachael Cayce, MD/ Elizabeth Gutmark, MD/ Katrina Spaunhurst, MD/ Joanna Chan, MD | 1127 Wilshire Blvd, Suite 909 Los Angeles, CA 90017 | Phone: (213)278-0021 | Fax: (213) 278-0973 |www.dtladerm.com |Info@dtladerm.com

AUTHORIZATION TO RECEIVE OR RELEASE HEALTHCARE INFORMATION

Patient's Name: ________________________________ Date of Birth: ______________________________

Parent/Legal guardian name: ____

Authorization to receive:

I authorize records to be sent to DTLA DERM from:

1. Name:_________________________________
Address:_________________________________
City, State:_______________________________
Tel: ____________________________________
Fax: ____________________________________
2. Name: _________________________________
Address: _________________________________
City, State: _______________________________
Tel: ____________________________________
Fax: ____________________________________
3. Name:_________________________________
Address: _________________________________
City, State: _______________________________
Tel: ____________________________________
Fax:_____________________________________

Authorization to release:

I authorize DTLA Derm to release records to:

1. Name: ___________________________
Address: ___________________________
City, State:__________________________
Tel: _______________________________
Fax: _______________________________
2. Name: ___________________________
Address: ___________________________
City, State:__________________________
Tel: _______________________________
Fax:_______________________________

O Myself:
Name: ____________________________
Address: ___________________________
City, State: _________________________
Email: _____________________________

- ☐ I would like an electronic copy of my record.
- ☐ I would like a copy mailed to me of my record. I understand there is a $.25 fee per page plus a $10 clerical fee in compliance with the California law.

I would like the following sent (check all that apply)

- ☐ Visit notes, including treatment, prescriptions, diagnoses
- ☐ Labs (blood work) and Pathology results from biopsies, excisions
- ☐ All health-related information
- ☐ Dates:
  From: _________/_________/__________ To: _________/__________/____________

Patient Signature: __________________________________ Date: __________________________

Parent/ Legal Guardian Signature: _____________________________ Date: ___________________

Hair Loss/Hair thinning/Alopecia

Patient History Form

We take hair loss very seriously due to the large impact it has on a patients' quality of life. We therefore devote a special time during the week for patients with this problem where more time, attention and detail can be given for this condition. As part of this, you need to be prepared for your visit. Your visit will only be focused on this condition. Hair loss appointments will not include skin checks, acne evaluation, cosmetics, etc.

ONSET

1. How long ago did the hair loss start? ______________________________
2. Did it happen rapidly "overnight"? YES OR NO
3. Who noticed the hair shedding/hair loss? ______________________________
4. Was your hair gray all of a sudden in a particular area? YES OR NO
5. Which family members have had hair problems (CIRCLE ALL THAT APPLY)
   a. Mom/Dad
   b. Siblings
   c. Children
   d. Grandparents
6. Is this the first and only time you have experienced hair loss? YES OR NO
   a. Is it different from the other time you experienced hair loss? Please explain.

____

____

____

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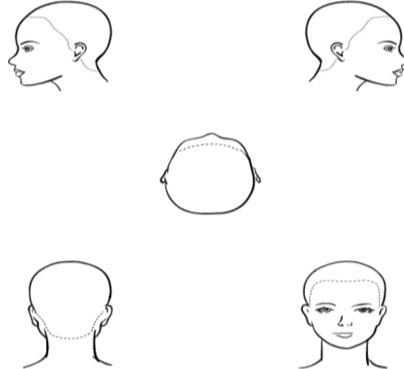
SYMPTOMS

7. Is the hair shedding (you can see the hair bulb) or is it breaking? ____________________
8. Does your hair have a dry texture? YES OR NO
9. Is your scalp?
    a. Flaking YES OR NO
    b. Itching YES OR NO
    c. Painful or tender YES OR NO
    d. Sensitive or irritated YES OR NO
    e. Greasy YES OR NO
    f. Red (assessed in the mirror or what other people say) YES OR NO
10. Does your scalp have a funny odor sometimes? YES OR NO
11. Do you dye your hair? YES OR NO
12. Do you have any divots/impressions/dots or ridges on your nails? YES OR NO
13. Where do you see hair?
    a. Home
    b. Shower
    c. Other: ____
14. How many hairs do you estimate you are losing at a time?
    a. 100 YES OR NO
    b. >100 YES OR NO
    c. I don't know, but the hair is in clumps YES OR NO
15. Where have you noticed hair loss (CIRCLE ALL THAT APPLY)?
    a. Top/front of scalp
    b. Sides of scalp
    c. Back of scalp
    d. Armpits
    e. Groin
    f. Eyebrows
    g. Legs
    h. Eyelashes

16. Draw on the diagram where the hair loss is the most?



17. Women, do you have hair growth on your?
    a. Chin/thick sideburns YES OR NO
    b. Chest/nipples YES OR NO
    c. Area below your belly button YES OR NO

TREATMENTS

18. What resources have you used to learn about hair loss?
    a. Internet YES OR NO
    b. Friends YES OR NO
    c. Any questions or concerns you have based on your research ______________

    ____

    ____

19. Have you seen another doctor for this problem? YES OR NO
    a. If yes, was lab testing performed? YES OR NO
       This must be brought to your visit or sent before your visit
    b. If yes, was a biopsy performed? YES OR NO
       This must be brought to your visit or sent before your visit

20. Are you using Rogaine/Minoxidil? YES OR NO
    a. Strength (2 or 5%) ______________________________
    b. How often (once or twice a day) ______________________________
    c. Are you consistent with use? YES OR NO
    d. How long have you used it? ______________________________
    e. Did it work? YES OR NO
    f. Did it cause more hair to fall out in the beginning? YES OR NO

g. Any side effects? ____
____

21. Are you using anything else to treat your hair loss?
 a. Biotin YES OR NO dose:________________
 b. Spironolactone/aldactone (dose) YES OR NO dose:________________
 c. Shampoo/conditioner system like viviscal YES OR NO
 d. Finasteride/Propecia YES OR NO dose:________________
 e. Dutasteride YES OR NO
 f. LED light helmets YES OR NO
 g. Ketoconazole shampoo YES OR NO
 h. Prednisone YES OR NO dose:________________
 i. Antibiotics (doxycycline, clindamycin, benzoyl peroxide) YES OR NO
 list:____
 j. Prior steroid injections YES OR NO
 k. Iron supplements (dose) YES OR NO dose:________________
 l. Other vitamins (list:) ____
____

22. Any side effects from treatments(i.e scalp irritation, dizziness, hair growth in unwanted areas, breast enlargement, etc) ____
____
____

23. Has any treatment helped more than others (explain)?______________________________
____

24. What goals or expectations do you have for treatment? ______________________________
____
____

SOCIAL IMPACT

25. What is your occupation? ____

26. How severely has it affected your life? ____
____
____
____

27. Are you fearful of becoming bald? ____
____

DERMATOLOGY LIFE QUALITY INDEX (adapted) – this screening will be repeated at future visits

Name: Date: Score:

The aim of this questionnaire is to measure how much your hair loss has affected your life OVER THE LAST WEEK. Please tick ☑ one box for each question.

1.	Over the last week, how **itchy**, **sore**, **painful** or **stinging** has your scalp been?	Very much	❒
		A lot	❒
		A little	❒
		Not at all	❒
2.	Over the last week, how **embarrassed** or **self conscious** have you been because of your hair loss?	Very much	❒
		A lot	❒
		A little	❒
		Not at all	❒
3.	Over the last week, how much has your hair loss interfered with you going **shopping** or looking after your **home?**	Very much	❒
		A lot	❒
		A little	❒
		Not at all ❒	Not relevant ❒
4.	Over the last week, how much has your hair loss influenced the **clothes** you wear like hats?	Very much	❒
		A lot	❒
		A little	❒
		Not at all ❒	Not relevant ❒
5.	Over the last week, how much has your hair loss affected any **social** or **leisure** activities?	Very much	❒
		A lot	❒
		A little	❒
		Not at all ❒	Not relevant ❒
6.	Over the last week, how much has your hair loss made it difficult for you to do any **sport**?	Very much	❒
		A lot	❒
		A little	❒
		Not at all ❒	Not relevant ❒

7.	Over the last week, has your hair loss prevented	Yes	❒	
	you from **working** or **studying**?	No	❒	Not relevant ❒
	If "No", over the last week how much has	A lot	❒	
	your hair loss been a problem at	A little	❒	
	work or **studying**?	Not at all	❒	
8.	Over the last week, how much has your	Very much	❒	
	hair loss created problems with your	A lot	❒	
	partner or any of your **close friends**	A little	❒	
	or **relatives**?	Not at all ❒	Not relevant ❒	
9.	Over the last week, how much has your	Very much	❒	
	hair loss caused any **sexual**	A lot	❒	
	difficulties?	A little	❒	
		Not at all ❒	Not relevant ❒	
10.	Over the last week, how much of a	Very much	❒	
	problem has the **treatment** for your	A lot	❒	
	hair loss been, for example by making	A little	❒	
	your home messy, or by taking up time?	Not at all ❒	Not relevant ❒	

Please check you have answered EVERY question. Thank you.

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Check the box(es) if you are experiencing any of the following:

- ☐ Problem with bleeding
- ☐ Excessive fatigue
- ☐ Dry eyes
- ☐ Unintentional weight loss or gain
- ☐ Staphylococcal infections
- ☐ Problems with scarring (hypertrophic or keloid)
- ☐ Artificial heart valve
- ☐ Artificial joints placed within the past two years
- ☐ Blood thinners (aspirin, warfarin)
- ☐ Defibrillator
- ☐ Allergy to lidocaine/anesthetics
- ☐ Allergy to topical antibiotic (Neosporin)
- ☐ Problems with healing
- ☐ Joint or back aches
- ☐ Change in vision or blurry vision
- ☐ Abdominal pain
- ☐ Migraines
- ☐ Irregular menses/periods
- ☐ Dry mouth
- ☐ Hair loss
- ☐ Rash with use of adhesive bandages
- ☐ Currently pregnant or planning a pregnancy
- ☐ Leg swelling
- ☐ Muscle Weakness

Past Medical History (Please circle all that apply)

Anxiety	Asthma	Hay Fever/Allergies	Depression	Diabetes
Kidney Disease	Liver disease	HIV/AIDS	Thyroid Problems	Leukemia
Lymphoma	Radiation Treatment		Sjogren's syndrome	Lupus

Past Surgical History: (please circle all that apply)
Mechanical Heart Valve Replacement
Biological Heart Valve Replacement

Joint Replacement within last 2 years
Bone Marrow Transplantation
Organ Transplantation
Skin Disease History: (please circle all that apply)

Acne Blistering Sunburns Dry Skin Eczema Flaking or Itchy Scalp
Sun sensitivity Psoriasis

Family History:

Eczema: siblings /mother / father / child / grandparents
Psoriasis: siblings /mother / father / child / grandparents

Medications: Please all medications you take from other doctors and **length of therapy**

____
____
____
____
____
____
____
____