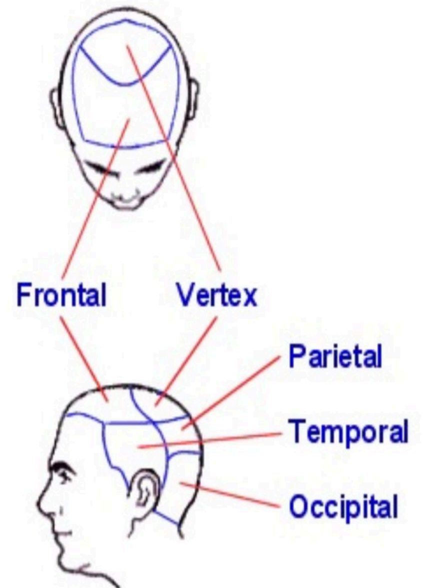
SKIN WELLNESS
P H Y S I C I A N S
Dermatology Redefined

Hair loss questionnaire

Patient name:_________________________________ MRN:____________________ Date:_________

1. What is your primary purpose for this visit? Please circle or number in order
   ____Diagnosis ____Medical treatment ____Second Opinion ____Consultation for plate-rich-plasma injection
2. Have you ever seen another doctor for your hair loss? YES NO
   Who? ____
   What did they say? ____
3. When did you last have a normal head of hair? ____________________
4. Was onset of hair loss sudden or gradual? ______________________
5. 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.)
6. Is your hair shedding? Shedding is defined as having excessive numbers of hairs falling out daily. Thinning is defined as having less hair to cover the scalp, with or without excessive hairs lost each day. Do you feel that you have been shedding excessive numbers of hairs (in the shower, on your hairbrush, etc)? YES NO ____________
7. How many hairs would you estimate you shed per day?
   <50 50-100 100-150 150-200 >200
8. Do you feel that your scalp hair is slowly thinning out over the top without losing excessive numbers of hairs daily? YES NO __________________
9. How often do you wash your hair? _________________
10. How often do you blow dry your hair? _______________
11. What hair products do you use? (concealment fibers/spray, medications, styling products, etc) ____________________________
12. 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? __________
13. Do you use hot combs, press and curl, curling irons, flat iron or otherwise apply direct heat to your hair? _________________________________
14. 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? _______________
15. Do you use a wig? YES NO __________________________
16. Does your scalp itch? Little Moderate A lot (Circle)
17. Does your scalp burn? Little Moderate A lot (Circle)
18. Does your scalp hurt? Little Moderate A lot (Circle)
19. Do you get sores in your scalp? YES NO
20. Do you pull or plug your hair? YES NO
21. Do you have seborrheic dermatitis (dandruff)? YES NO Psoriasis? YES NO
22. Do you use herbs or supplements? YES NO Name: __________________________
23. If you are on birth control pills, which one? ____
    Have you recently started? __________ When? ______________________________________
    Or stopped your birth control pills? __________ When? _______________________________



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24. Are you on any other type of hormone treatment? ____________________
    Which one? ____________ How long? ____________
    Or stopped? ______ When? ____________
25. If applicable, are your menstrual periods regular? ______ Normal flow? ______
    If not, what is happening? ____________ How long? ______
26. Have you gone through menopause? ______ Age? ______
27. Have you had difficulty becoming pregnant? YES NO
28. Have you had a hysterectomy? YES NO; When? ______
29. Have your ovaries been removed? YES NO; When? ______
30. Are you on any type of weight loss diet? ____________________
    Are you on a low protein diet? ____________________
    Are you a vegetarian or vegan (type)? ____________________
31. Do you have a functioning carbon monoxide detector at home? At history of high carbon monoxide level at home?
    YES NO__________
32. 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?____________
33. What medical problems do you have? ____________________
34. Have you had any recent lab work done to diagnose the hair loss? YES NO
    Please include copies of any lab results.
35. Have you ever had a biopsy of your scalp? YES NO
    If so, where & when? Please include result. ____________________
36. Do you have?
    a. Severe headaches ☐ Yes ☐ No
    b. Double vision ☐ Yes ☐ No
    c. Excess facial hair ☐ Yes ☐ No
    d. Excess body hair (especially abdomen or nipples) ☐ Yes ☐ No
    e. Cystic Acne ☐ Yes ☐ No
    f. Discharge from breast ☐ Yes ☐ No
    g. Deepening of voice ☐ Yes ☐ No
    h. Enlargement of clitoris ☐ Yes ☐ No
    i. Polycystic ovary disease ☐ Yes ☐ No
37. Have you had in the last 3-12 months?
    a. High fever ☐ Yes ☐ No
    b. Childbirth ☐ Yes ☐ No
    c. Severe infection ☐ Yes ☐ No
    d. Flare of chronic illness ☐ Yes ☐ No
    e. Major surgery ☐ Yes ☐ No
    f. Over or under active thyroid ☐ Yes ☐ No
    g. Low protein diet ☐ Yes ☐ No
    h. Low iron in blood ☐ Yes ☐ No
    i. Severe psychological stress ☐ Yes ☐ No
    j. Start or stop birth control pills ☐ Yes ☐ No
    k. Start or stop hormone treatment ☐ Yes ☐ No
    l. Start or stop beta blocker medication ☐ Yes ☐ No
38. Do you see a rash in your scalp or on your face? ______
    If yes, please describe. ____________________

39. Treatments previously tried? (Rogaine, Vitamins, Shampoos, pills, surgeries etc.)

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

40. How does your hair loss impact your quality of life and your psychosocial health?

____

41. What do you think is the cause of your hair loss? Or any possible contributing factors?

____

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