Name:___________________________________ Date: ______________________

Hair Loss Questionnaire

1. How long have you had hair loss? _________________________

2. Since that time, how has your hair loss been? (circle one) BETTER WORSE SAME

3. Which part of your head has hair loss? ALL OVER FRONT / HAIRLINE CROWN
   BACK / LOWER OTHER:_________________________

4. How rapid was the hair loss? SUDDEN GRADUAL

5. _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 hair brush, etc)? YES NO

6. Do you feel that your scalp hair is _slowly thinning out_ over the top without losing excessive numbers of hairs daily? YES NO

7. Are your hairs (circle one): BREAKING OFF or COMING OUT AT THE ROOTS

8. Within ***6 months PRIOR*** to the onset of hair loss:
   Have you been started on any new medications? YES NO
   If YES, please list ____
   Have you had any hormone pills or birth control pills started or stopped? ___________
   Have you been experiencing any significant medical issues in your life, such as the birth of a child, surgery, illness, or hospitalization? _________________________
   Have you been experiencing any significant stress, such as divorce, family illness or cancer, or work issues? ____
   Have you had any recent weight loss or change in your diet? _____________________

9. Any history of anemia or low iron? YES NO; Are you on any treatment? ____________

10. Any history of thyroid disorders? YES NO; Are you on any treatment?_____________

11. Are you actively dieting? YES NO; If so, what type of diet? _______________________

12. Are you a vegetarian or vegan? YES NO

13. Have you had any recent lab work done to diagnose the hair loss? YES NO
    Please include copies of any lab results.

14. Does your scalp itch or sometimes burn or hurt? YES NO

15. Do you have a rash or flaking in your scalp? YES NO

16. List any family members with hair loss or thinning hair (any grandparents, parents, or siblings)? ____

17. Please list all the prescription medications, supplements, and shampoos/solutions that you have tried for your hair loss:

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

18. Please list the names and dosages of all medications, over-the-counter pills, and hormone pills that you are currently taking and circle the ones that you were taking when your hair began to fall out.

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19. Please list the names and dosages of all vitamins and natural supplements that you are taking and circle the ones that you were taking when your hair began to fall out:

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____

20. How often is your hair colored, chemically processed, or straightened?

☐ Never ☐ Every _____ weeks ☐ Every _____ months

21. *For Women*:

Are your periods: REGULAR or IRREGULAR

Do you have excessive hair on your chin, face, abdomen, or around nipples?

(circle any that apply) or NO

Have you had difficulty becoming pregnant? YES NO

Are you postmenopausal? YES NO; At what age? _____________

Have you had a hysterectomy? YES NO; When? ______________

Have your ovaries been removed? YES NO; When? ____________

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

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