Name:_____ Date: _____

Hair Loss Evaluation

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.

_____

_____

_____

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:

_____

_____

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?

_____

_____