HAIR LOSS QUESTIONNAIRE: PLEASE FILL OUT IF APPLIES TO YOU

Name: _____ Date: _____

When did you first notice hair loss/thinning? _____

Circle the description that most accurately applies to your condition:
1) Coin-shaped bald spot(s) with normal-looking scalp skin (if so, you need only answer the 4 questions marked with an *)
2) Localized area(s) of hair loss with rash/abnormal scalp skin
3) One or more areas of thinning; which areas: _____
4) Thinning all throughout the scalp

*Did the hair loss/thinning happen suddenly (overnight) or gradually over time? _____

In the 3-6 months prior to the onset of hair loss, did you experience:

YES	NO				
☐	☐	surgery	☐	☐	hospitalization
☐	☐	major accident/severe injury	☐	☐	major illness or high fever
☐	☐	pregnancy	☐	☐	starvation/major change in diet
☐	☐	major emotional trauma (divorce, death of a loved one)			

Miscellaneous:

YES	NO	
*☐	☐	Have you ever had a thyroid disorder or anemia?

*When were you last checked for both of these? _____

☐	☐	Would you say that you eat a nutritionally balanced diet?
☐	☐	Do you take vitamin A?
☐	☐	Do you take other vitamins, minerals, or herbal supplements: _____

Medications you take and length of time you have taken them:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Had you taken any other medications, even short-term (ex. course of antibiotics), in the 3-6 months prior to the onset of your hair loss?

1) _____ 2) _____

Do you have a family history of thinning of the hair? Which relatives/family members?

1) _____ 3) _____
2) _____ 4) _____

Have you experienced:

YES	NO		YES	NO	
☐	☐	irregular periods	☐	☐	recent skin rashes
☐	☐	unexplained increased muscle mass	☐	☐	changes in the nails
☐	☐	deepening of the voice	☐	☐	itching of the scalp
☐	☐	unexplained joint aches			
☐	☐	unexplained fatigue			
☐	☐	low grade fever			

Do you:

YES	NO	
☐	☐	bleach/dye your hair (circle); frequency: _____
☐	☐	blow dry your hair
☐	☐	perm/straighten your hair (circle); frequency: _____
☐	☐	wear hair pulled back in braids, ponytails, etc.

*What treatments/medications have you received for this condition? _____

_____

Signed by physician: _____ Date: _____