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HAIR LOSS QUESTIONNAIRE

Name_____ Date _____ Chart _____ Age ____ Sex ____

- When did you first notice your problem?
- Who first noticed your hair loss? You, family member, friend, hairstylist
- Did you first notice thinning or excess shedding?
- Has your problem been slowly or rapidly progressive?
- Has the problem been localized in patches or does it involve your entire scalp?
- Do you think that the cause of your problem is increased shedding, hair breakage, or failure to grow?
- Do you think that you are losing more than 100 hairs a day?
- Do you think that your hair grows slowly, fast, or not at all?
- Has there been a change in the color, texture, waviness, brittleness, or thickness of individual hairs?
  If so please explain.
- What is your natural hair color?
- Do you consider your individual hairs to be thin, average, or thick?
- Do you have straight, mild wave, or curly hair?
- Has your hair become more unmanageable?
- Do you have any excess facial or body hair? If yes, where?
- Do other family members have excess facial or body hair? If yes, who?

HAIR CARE:

- How do you take care of your hair?
- Do you have your hair professionally done? If yes, how often?
- How often do you shampoo?
- Have you changed the frequency of shampooing?
- What is your usual shampoo?
- Have you recently changed shampoos?
- Please **CIRCLE** any of the things listed you do to your hair and how often:
  Put your hair in rollers
  Electric rollers/curling iron
  Sleep with rollers
  Use rubber-bands in your hair

Wear a ponytail or braids

Use hair spray

Use styling gels/mousse

Bleach your hair

Color your hair. If so, rinse, semi-permanent, permanent, how often?

Perm you hair. If yes, how often and when was then last treatment?

Use hair straightener

Use cold wave solution

Use oil treatments

Use hot combs

Use hair dryer

Pull, twirl, or play with your hair

Teasing

- Are there any other "special" treatments you do to your hair?

SCALP DISEASE:

- Do you have any scalp diseases such as dandruff, seborrhea, eczema, psoriasis, or other scalp conditions?
- Do you consider your scalp and hair to be oily, dry, or neutral?
- Does your scalp itch, burn, pain, hurt, tingle, or have any other abnormal sensation?
- Do you use any over-the-counter or prescribed medicated shampoos, scalp lotions, herbal products, or other "special" treatments for your hair or scalp?
- Do you groom your hair with a brush or comb? How many times in an average day?

MEDICAL HEALTH:

- Have you recently lost or gained more than ten pounds? If yes, over what time period and what were the circumstances?
- Are you on any special diet? If yes, what is the nature of the diet and how long have you been on it?
- Please **CIRCLE** if you have or have you had any of the following:

  Iron deficiency anemia, thyroid disease, arthritis, sun sensitivity?
- Do you have problems with either too much or too little perspiration?
- Do you have dry skin other than during the winter months?
- Do you have brittle fingernails?
- Have you been severely ill or been hospitalized within the past six months?
- Have you run a temperature greater than 102 during the past six months?
- Have you had surgery in the hospital in the past six months?

- Have you been under emotional stress recently?
- Have you had any change in your mental health recently?
- Have you taken any medication for your mental health?
- Have you had any chemical exposure on a chronic basis in either the workplace or at home?
- What medicines are you taking or were you taking within three months of noting your hair loss problem?

MENSTRUAL HISTORY:

- At what age did you have your first period?
- Are your menstrual cycles regular or irregular?
- Has this pattern changed recently?
- Have you gone thru menopause? Age of onset? (Natural or the result of surgery)
- How many times have you been pregnant? Number of children?
- Date of last pregnancy?
- Did you experience hair loss associated with or after any of your pregnancies?
- Have you ever taken birth control pills or hormone replacement therapy?

If yes, when and for how long?

If you are no longer taking hormones, when did you stop?

- Did you experience any hair loss while you were on birth control pills or hormone replacement therapy or within three months of stopping them?

FAMILY HISTORY:

- Is there any history of hair loss in brothers, sisters, parents, or grandparents on either side?

If yes, please describe.

- Is there any history of thyroid disease in your family?

TREATMENT:

- What have you done to treat your hair loss problem?
- Have you discussed your problem or had treatment recommended to you by your hairstylist or pharmacist? If yes, what suggestions were made?
- Have you been evaluated or treated by another physician for this problem? If yes, what tests or treatments were recommended?
- Have you ever had this problem previously? If yes, when? How long did it last? How were you treated?
- Have you used any over-the-counter, advertised, or prescription medications; such as pills, topical solutions and shampoos, herbal treatments, or other treatments in an effort to treat your problem?
- What do you think is causing your hair problem?