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Name _____ Date _____

HAIR LOSS QUESTIONNAIRE

1. When did you first notice that you were losing your hair? _____
   What did you see? ☐ Hair "coming out"/shedding ☐ Hair looked thinner on scalp
   ☐ Other: _____

2. Have you lost any of the hair in your eyebrows? ☐ Yes ☐ No

3. Have you lost any hair on the rest of your body? ☐ Yes, where _____ ☐ No

4. Is hair loss worsening? ☐ Yes ☐ No
   When did this start? _____
   What makes you think it is worsening? _____

5. Tell us about hair loss in your family members (check all that apply)

	Has a lot	Some thinning	Some balding	Many bald spots
Father				
Mother				
Brother				
Sister				

6. Were you pregnant at any time before or during the hair loss? ☐ Yes ☐ No
   When did the pregnancy end? _____

7. Have you been seriously ill at any time before or during the hair loss? ☐ Yes ☐ No
   If yes please describe what and when _____
   Were you hospitalized during the time you experienced hair loss? ☐ Yes ☐ No
   If yes, explain_____

8. Any severe stress during time of hair loss? ☐ Yes ☐ No
   If yes please explain _____
   _____

9. Have you tried any special diets during this time or had weight loss or gain?
   _____
   _____

10. Please list medications you take. Put a check next to any you were taking when your hair started to fall out. _____
    _____
    _____

11. Please list other medications you were taking when your hair began to fall out that you are no longer taking:
    _____
    _____

12. Please list vitamins or supplements: _____
_____
_____
_____

13. For women: Are you menopausal? ☐ Yes ☐ No
If yes, when did this occur _____.
Were cycles regular before menopause? ☐ Yes ☐ No
If not menopausal, are your cycles regular? ☐ Yes ☐ No

14. For women: did you ever use birth control pills to make your periods regular? ☐ Yes ☐ No

15. For women: do you have unwanted or excessive hair growth elsewhere on your body? ☐ Yes ☐ No
If yes, where? _____

16. How often do you shampoo? Every _____ days. Last shampoo_____

17. How often do you chemically process or straighten your hair (relaxers, other)?
☐ Never ☐ Once a week ☐ Once every 2-3 weeks
☐ Once every 1-2 months ☐ A few times a year

18. How often do you use heat process or straighten your hair (i.e. Blow dry/flat iron/curling iron)?
☐ Never ☐ Once a week ☐ Once every 2-3 weeks
☐ Once every 1-2 months ☐ A few times a year

19. How often is your hair dyed, highlighted, or other color treatment?
☐ Never ☐ Once a week
☐ Once every 2-3 weeks ☐ Once every 2-3 months

20. What types of styling practices have you done in the past?
☐ Braiding ☐ Weaves
☐ Tight hairstyles (ponytails) ☐ Other: _____

21. Do you have symptoms in your scalp? ☐ Yes ☐ No
If yes, which? ☐ Itch ☐ Tenderness ☐ Pain ☐ Burning ☐ Other: _____
Where on your scalp do you feel these symptoms? _____

22. Have you ever had a scalp biopsy? ☐ Yes ☐ No

23. Have you had blood tests to check for reasons for hair loss? ☐ Yes ☐ No

24. Have hormones been checked? ☐ Yes ☐ No

25. Have you ever had a thyroid condition? ☐ Yes ☐ No

26. Have you ever taken thyroid medication? ☐ Yes ☐ No

27. Have you ever been anemic (low iron)? ☐ Yes ☐ No

28. Have you ever had a low vitamin D level? ☐ Yes ☐ No

29. Is there a family history of autoimmune disease? ☐ Yes ☐ No

	Self (check all that apply)	Family Member (state their relationship to you)
Lupus		
Rheumatoid Arthritis		
Fibromyalgia		
Vitiligo		
Alopecia Areata		
Pernicious Anemia		
Celiac Disease		
Type 1 Diabetes		
Other:		

30. What prescription and over the counter treatments have you tried for your hair loss and did they help? How long did you use them?

_____
_____
_____
_____

31. What do you think is the cause for your hair loss

_____
_____
_____
_____
_____

32. Would you like to provide any other information regarding your hair loss?

_____
_____
_____
_____