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Initial Consult for Hair Loss Questionnaire

Name: _____ **DOB:** _____

History of Hair Loss and Scalp Health

What type of hair loss are you experiencing (please check off all that apply)?

Bald patches ☐
Excessive shedding ☐
General loss/overall thinning ☐

Areas affected by hair loss: Scalp ☐ Other areas ☐: _____

Associated symptoms in the scalp, such as itching, burning, pain or flaking?

Itch?	No ☐	Mild ☐	Moderate ☐	Severe ☐
Burning?	No ☐	Mild ☐	Moderate ☐	Severe ☐
Pain?	No ☐	Mild ☐	Moderate ☐	Severe ☐
Flaking?	No ☐	Yes ☐		

How long (approximately) have you been experiencing hair loss? _____

Was onset of hair loss: Sudden ☐ or Gradual ☐

Since onset, has it gotten: Better ☐ Worse ☐ or Stayed the same ☐

Any hair loss in men in your family? No ☐ Yes ☐ If YES, who? _____

Any hair loss in women in your family? No ☐ Yes ☐ If YES, who? _____

What treatments has the patient tried, and for how long have you used them?

_____

_____

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Hair Care and Styling

How often do you wash your hair? _____

How often do you use heat styling (curl/straighten, blow dry, etc.)? _____

How often do you color your hair? _____

How often do you perm or chemically relax your hair? _____

Do you regularly have any of these hair styles that increase tension or tugging on hair:

- ☐ Ponytails
- ☐ Braids
- ☐ Twists
- ☐ Dreadlocks
- ☐ Weaves
- ☐ Extensions
- ☐ Headbands

How often do you use any of the above? _____

Health History

Do you adhere a special diet, such as vegetarian or vegan (please specify)? _____

If YES, for how long have you followed this diet? _____

Have you had any blood work done recently? _____

Have you ever had a scalp biopsy? _____

Do you have:

- ☐ Psoriasis
- ☐ Anemia
- ☐ Hyper or Hypothyroid
- ☐ Cystic Acne
- ☐ Enlargement of clitoris
- ☐ Excess body or facial hair
- ☐ Lichen Planus
- ☐ Syphilis
- ☐ Deepening of voice
- ☐ Polycystic ovary disease
- ☐ Any autoimmune disease (please list): _____

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In the last 3-12 months, have you experienced?

- ☐ High fever
- ☐ Childbirth
- ☐ Severe infection
- ☐ Flare of chronic illness
- ☐ Major surgery
- ☐ Start or stop beta blocker medication
- ☐ Start or stop hormone treatment
- ☐ Start or stop birth control pills
- ☐ Weight loss
- ☐ Weight gain

Please explain if you checked off any of the above: _____

_____

Have you had any blood work done recently? _____

Have you ever had a scalp biopsy? _____

Have you experienced a major emotional or physical event? _____

_____

Are there any additional comments about your hair that you want to share? _____

_____

Female patients

If you are premenopausal, do you have a regular 28-day cycle? _____

Do use you use any form of hormone-based contraception? _____

If you are post-menopausal, at what age did you go through menopause? _____

Do you use hormone replacement therapy? _____

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