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MASRI-FRIDLING DERMATOLOGY GROUP | PRIVIA MEDICAL GROUP

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?