LIMMER DERMATOLOGY
Your Skin. Our Specialty.

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Hair Loss Questionnaire

Background of Hair Loss

When did you first start noticing your hair loss? _____

What did you notice at that time?

□hair "coming out" or shedding □hair looked thinner on scalp

□(other)_____

Shedding is defined as having excessive numbers of hairs falling out daily. **Thinning** is defined as having less hair to cover the scalp, with or without excessive hairs lost each day.

Do you feel that you have been **shedding** excessive numbers of hairs (in the shower, on your hair brush, etc.)?
YES or NO

Do you feel that your scalp hair is slowly **thinning** out over the top without losing excessive numbers of hairs daily?
YES or NO

How rapid was the hair loss? SUDDEN or GRADUAL

Are your hairs (circle one): BREAKING OFF or COMING OUT AT THE ROOTS

Do you have round areas of complete hair loss (Alopecia Areata)? YES or NO

What areas are your biggest concerns?

_____ Frontal Hairline _____ General thinning over entire scalp _____ Crown

_____ Eyebrows _____ Sideburns _____ Facial Hair

_____ Temples Receding _____ Other: _____

Have you had a biopsy of your scalp to evaluate your hair loss problem? YES or NO
Please provide a copy of the biopsy report.

Have you had blood tests done to evaluate your hair loss problem? YES or NO
Please provide a copy of the lab report.

Within 1 year PRIOR to the onset of hair loss:

Have you been started on any new medications? YES or NO
If YES, please list _____

Have you been experiencing any significant medical issues in your life, such as the birth of a child, surgery, illness, or hospitalization? YES or NO
If YES, please list _____

Have you been experiencing any significant stress, such as divorce, family illness or cancer, or work issues? YES or NO
If YES please list _____

Have you had any recent weight loss or change in your diet? _____

Any history of anemia or low iron? YES or NO Are you on any treatment? _____

Any history of thyroid disorders? YES or NO Are you on any treatment? _____

Are you actively dieting? YES or NO If so, what type of diet? _____

Are you a vegetarian or vegan? YES or NO

Do you have symptoms on the scalp (ex itching, burning, pain, dandruff)? YES or NO

Do you have hair loss anywhere else on your body? YES or NO
Where (other than scalp) is the hair loss located? _____

List any family members with hair loss or thinning hair (any grandparents, parents, or siblings)
_____

How often is your hair colored, chemically processed, or straightened?
□ Never □ Every _____ weeks □ Every _____ months

What is your current regime for your hair loss? (check any that apply) □ Spironolactone □ Finasteride 1mg (Propecia)
□ Minoxidil (Rogaine) □ Biotin □ Viviscal □ Nutrafol
□ Other(s): please list_____

Have you ever had a hair transplant procedure before? YES or NO

If yes, please provide details (when/where/how many grafts):_____

For Women:

Have you been pregnant at any time before or during the hair loss? YES or NO
If yes, when did the pregnancy end? _____

Have you had any hormone pills or birth control pills started or stopped? YES or NO
If yes, please list _____

Are your periods: REGULAR or IRREGULAR

Do you have excessive hair on your chin, face, abdomen, or around nipples? (circle any that apply) or NO

Have you had difficulty becoming pregnant? YES or NO

Are you postmenopausal? YES or NO At what age? _____

Have you had a hysterectomy? YES or NO When? _____

Have your ovaries been removed? YES or NO When? _____

Medical History: List all medical conditions you are being treated for:

_____

_____

Medications: list all prescriptions, over-the-counter, supplements and vitamins you are taking:

_____

_____

Allergies: _____

_____

Printed Name **Signature** **Date**