LDA
LINNELL
DERMATOLOGY | AESTHETICS

HAIR LOSS QUESTIONNAIRE

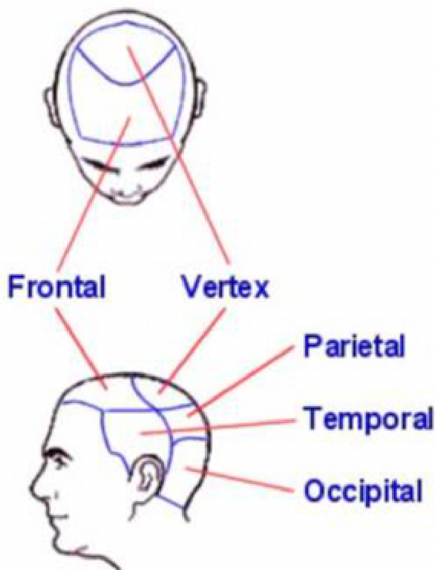
Name: ____ **Date:** __________
Age: ____________ **Height:** _____________ **Weight:** _______

YOUR HAIR HISTORY:

1. When did you last have a "normal" head of hair? ______________________
2. How rapid was your hair loss? ◻Sudden *or* ◻Gradual
3. How long have you had "hair loss?" ______________________
4. How has your hair loss been since it started? ◻Better *or* ◻Worse *or* ◻Same
5. Is your hair coming out? ◻"by the roots" *or* ◻"breaking off in the middle"

***SHEDDING** is defined as excessive numbers of hairs falling out daily (normal loss is ~100 hairs per day)
***THINNING** is defined as having less hair to cover the scalp, with or without excess hairs lost each day.

1. Are you SHEDDING excessive numbers of hairs (on your shower, pillow, hairbrush, etc.)? ◻Yes *or* ◻No
2. Is your scalp hair THINNING gradually over the top? ◻Yes *or* ◻No
3. List ANY family members with hair thinning, or baldness: ______________________
   ____
4. Do you feel like your front hairline was moved back? ◻Yes or ◻No
5. Does your scalp itch (check one)? ◻None / ◻Mild / ◻Moderate / ◻Severe
6. Does your scalp burn or hurt? ◻Yes *or* ◻No
7. Do you get bumps or sores in your scalp? ◻Yes *or* ◻No
8. Do you have rashes (redness or flaking) in your scalp? ◻Yes *or* ◻No
   If yes, please describe:
   ____
9. Shade in areas of hair loss on the diagram AND check below:



◻Frontal
◻Hairline
◻Vertex
◻Temporal
◻Parietal
◻Occipital
◻Entire Scalp

HAIR CARE HISTORY:

1. How often do you wash your hair? ____________________
2. What hair products do you use for regular maintenance (shampoo, conditioner, hair gel, mousse, spray)? ____________________
3. Do you use any of the following? ☐Hot Rollers ☐Ponytails ☐Braids ☐Twists ☐Locks ☐Extensions ☐Weaves
   How long? ______________ How often? ______________
4. Do you use any of the following? ☐Hot combs ☐Press & Curl ☐Curling Irons ☐Other direct heat products
5. What type of hair chemicals do you use on your hair? ☐Hair dye ☐Permanent Wave ☐Relaxer
   How long? ______________ How often? ______________
6. Any scalp surgery, face lift, or brow lifts? ____________________
7. List ALL special treatments or medications you use for your scalp or hair?
   ____
   ____
   ____

MEDICAL HISTORY:

1. Did your hair issues begin after any change in medications, supplements, or hormones?
   ____
2. Medications (**ALL** prescriptions AND over-the-counter)
   ____
   ____
3. Supplements, Herbs, Vitamins, Essential Oil:
   ____
   ____
4. Are you on any hormone treatment (including ANY birth control)?
   ____
5. Have you started or stopped any hormone?
   ____
6. Do you have menstrual periods? ☐Yes *or* ☐No
   If yes, is it regular? ☐Yes or ☐No
   If not, what is happening? ____________________
7. Have you gone through menopause? ☐Yes *or* ☐No
   If yes, what was the age of menopause? ____________________

MEDICAL HISTORY (CONTINUED):

8. What major medical problems do you have? ____

____

9. Do you have any of the following?

- Excess facial hair? ▫Yes *or* ▫No
- Excess body hair? ▫Yes *or* ▫No
- Cystic acne? ▫Yes *or* ▫No
- Polycystic ovarian syndrome? ▫Yes *or* ▫No
- Discharge from nipples? ▫Yes *or* ▫No

10. Have you had any of the following in the **last 12 months**?

- Weight loss? ▫Yes *or* ▫No If yes, how much? ______________________________________
- Dramatic change in diet? ▫Yes *or* ▫No. Please select which diet: ▫Vegetarian ▫Vegan ▫Keto
- Childbirth? ▫Yes *or* ▫No
- High fever? ▫Yes *or* ▫No
- COVID or Flu? ▫Yes *or* ▫No
- Severe infection? ▫Yes *or* ▫No
- Flare of chronic illness? ▫Yes *or* ▫No
- Any surgery? ▫Yes *or* ▫No
- Over or under-active thyroid? ▫Yes *or* ▫No
- Anemia or low iron? ▫Yes *or* ▫No
- Start or stop birth control pills? ▫Yes *or* ▫No
- Start or stop hormone replacement? ▫Yes *or* ▫No
- Start or stop beta blocker medication for high blood pressure or heart disease? ▫Yes *or* ▫No
- Severe psychological stress? ▫Yes *or* ▫No
  If yes please specify: ▫Divorce ▫Family illness ▫Cancer ▫Work issue ▫Financial ▫Other

****DON'T FORGET TO BRING THIS COMPLETED FORM AND COPIES OF ANY AND ALL LAB REPORTS FROM ANY LABS YOU HAVE HAD IN THE LAST 6 MONTHS****