

- Take your time filling this form. Check your calendar for exact timing for your answers.
- **An appointment made for hair loss requires a detailed history and physical exam with our providers which takes up the full length of the appointment. If other skin related concerns would like to be addressed please schedule a separate appointment.**
- Please bring this completed form and copies of all lab reports that you have had in the last months.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Race/Ethnicity:** \_\_\_\_\_

**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"

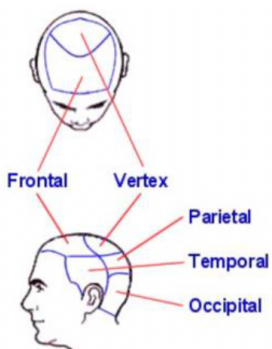
**\*SHEDDING** is defined as excessive numbers of hairs falling out daily (normal loss is ~100 hairs per day)

**\*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? \_\_\_\_\_

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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 MONTHS\*\***