

SAYBROOK DERMATOLOGY, LLC
HAIR LOSS QUESTIONNAIRE

- Take your time filling out this form. Check your calendar for exact timing for your answers. Include every detail and **BE HONEST!**
- Your **entire** appointment will be dedicated to your hair loss. We will not be doing a skin cancer screening or discussing other skin issues (lesions/moles, acne, rashes, hives, etc.)
- Please bring copies of any and all lab reports that you have had in the last month(s).

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? Circle One: Sudden or Gradual
3. How long have you had “hair loss”? _____
4. How has your hair loss been since it started? Circle One: Better Worse Same
5. How is your hair coming out? Circle One: “by the roots” or “breaking off in the middle”

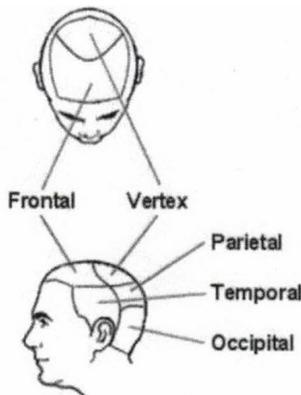
SHEDDING is defined as excessive numbers of hairs falling out daily (normal loss is ~100 hairs per day).

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 pillow, hairbrush, in your shower, 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. Shade in areas of hair loss on diagram AND circle below:

Circle areas affected: Frontal / Hairline / Vertex / Temporal / Parietal / Occipital / ENTIRE SCALP



5. Do you feel like your front hairline has moved back? Yes or No
6. Does your scalp itch? Circle One: None / Mild / Moderate / Severe
7. Does your scalp burn or hurt? Yes or No
8. Do you get bumps or sores in your scalp? Yes or No
9. Do you have rashes (redness or flaking) in your scalp? Yes or No
If yes, please describe: _____

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 (circle)? Hot Rollers / Ponytails / Braids / Twists / Locks / Extensions / Weaves
4. Do you use hot combs, press & curl, curling iron or otherwise apply direct heat to your hair?

5. What type of hair chemicals do you use on your hair? Circle: 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:

**Most important: Did your hair issues begin after any change in medications, supplements, hormones?*

1. Medications (**ALL** prescriptions AND over-the-counter): _____

2. Supplements, Herbs, Vitamins, Essential Oil: _____
3. Any hormone treatment (include ANY birth control): _____
4. Have you stopped or started any hormone? _____
5. Do you have menstrual periods? Yes or No If yes, is it regular? Yes or No
If not, what is happening? _____
6. Have you gone through menopause? Yes or No Age of Menopause: _____
7. Have you had difficulty becoming pregnant? Explain: _____
Hysterectomy? Yes or No
Do you still have ovaries? Yes or No If no, when removed? _____
8. What major medical problems do you have? _____

9. Do you have:
Excess facial hair? Yes or No Polycystic ovarian syndrome? Yes or No
Excess body hair? Yes or No Discharge from nipples? Yes or No
Cystic acne? Yes or No
10. Have you had in the last 12 months:
Weight loss? Yes or No How much? _____
Dramatic change in diet? Yes or No Circle: Vegetarian / Vegan / Keto
Childbirth? Yes or No Flare of chronic illness? Yes or No
High fever? Yes or No Over or under active thyroid? Yes or No
COVID or Flu? Yes or No Anemia or low iron? Yes or No
Severe infection? Yes or No Start or stop birth control pills? Yes or No
Any Surgery? 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
Several psychological stress? Yes or No
If yes, circle: Divorce / Family Illness / Cancer / Work Issues / Financial Issues

**** DO NOT FORGET TO BRING COPIES OR ANY AND ALL LAB REPORTS
FROM ANY LABS YOU HAVE HAD IN THE LAST MONTHS ****