

NAME _____

DATE _____

HAIR LOSS QUESTIONNAIRE

Please tell me more about your hair loss condition by answering the following questions. For some questions you will need to mark the YES or NO box at the right. For other questions, simply write your answers in the spaces provided.

1. When did you *FIRST* notice that you were losing your hair? _____

2. Have you recently noticed that your hair loss was worsening? YES NO
If yes, when did you begin to notice it was worsening? _____

3. Please mark the box that best describes your family members' scalp hair
(If you have more than one brother or sister, mark the box that describes the brother or sister who has the least amount of hair):

	Has a lot of hair	Has some thinning	Has a small bald area	Has a large bald area
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Have you been pregnant at any time during the past year? YES NO
If yes, when did the pregnancy end? _____

5. Have you had a serious illness during the past year? YES NO
If yes, approximately how long ago? _____

6. Have you been hospitalized during the past year? YES NO
If yes, when did you leave the hospital? _____

7. Have you been under a severe amount of stress during the past 6 months? YES NO

8. Have you started any special diets during the past year? YES NO

9. Are you a vegetarian? YES NO

NAME _____

10. Please list the names of all the medications you are currently taking in the space below.
Circle the ones that you were taking when your hair began to fall out.

11. Please list any additional medications that you were taking when your hair began to fall out but that you are no longer taking:

12. Please list any vitamins or natural products that you are taking:

13. Do you get your menstrual period every month? **YES** **NO**

If yes how often does your period come? Every _____ days

Have you needed to take birth control pills to make your periods regular? **YES** **NO**

14. Have you experienced difficulty becoming pregnant? **YES** **NO**

15. Do you have unwanted or excessive hair growth anywhere on your body? **YES** **NO**

16. How often do you wash/shampoo your hair? Every _____ days

17. How often is your hair chemically processed or straightened?

Never Once a week Once every 2 – 3 weeks Once every 1 – 2 months

A few times a year

NAME _____

18. Have your hormones ever been checked to evaluate your hair loss problem? YES NO

If yes, when? _____

What was the result? _____

19. Have you ever been told by a doctor that you have a thyroid condition? YES NO

20. Have you ever been treated with thyroid hormone? YES NO

21. Have you ever been told by a doctor that you have a low iron level? YES NO

22. Does your scalp itch a lot or sometimes burn or hurt? YES NO

23. Please list all the prescription and non-prescription treatments that you have tried for your hair loss condition:

Treatment	When was it tried?	For how long?	Did it help?

24. What do you think is the cause of your hair loss?
