Hair Questionnaire

Name___________________________________ **Date**_______________

Age_________ **Sex**_______________

Please complete this form to the best of your ability <u>before</u> your scheduled appointment.

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.

1. Do you feel that you have been shedding excessive numbers of hairs? (In shower or tub, hairbrush, on counters, floors or pillows)

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2. Do you feel that your scalp hair is slowly thinning out over the top without losing excessive numbers of hair daily?

____

3. Of the two events, which was the first thing that you noticed, shedding or thinning?

____

4. Are your hairs

a) Breaking off, OR

b) Coming out with the roots attached (with a white "club" root at the end)?

5. Approximately how long have you noticed thinning or shedding?

____

6. Is your hair being lost

a) in patches, OR

b) diffusely (evenly allover scalp), OR

c) is it most noticeable over the top of the scalp

7. Are you losing hair in areas other than your scalp?

____

____

8. Is there a family history of males with male pattern baldness or of females with thinning over the top of the scalp? (Please include grandparents, parents, siblings, children, aunts and uncles.)

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- Anyone with patchy hair loss?

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9. Is there any personal or family history of allergies, hay fever, eczema or asthma?

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- Is there any personal or family history of autoimmune diseases such as early onset diabetes, loss of skin pigment, rheumatoid arthritis or thyroid disease?

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10. Please indicate what you eat on an average day? Please include breakfast, lunch and dinner. We are particularly interested in protein intake.

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11. Past Medical History. Please specify if you have had a recent illness, surgery, fever, childbirth or have been under psychological stress. Please include dates beginning with the most recent.

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12. List all medications you are currently taking or have taken within the past six months. Include all prescription medications, over-the-counter and herbal supplements, hormones or birth control pills.

13. Have you been on a weight loss diet within the last six months? If so, please indicate how much weight was lost and what diet you were on.

14. Do you have a history of thyroid disease or have you ever taken medication for over- or under-reactive thyroid? If so, when?

15. Have you ever been iron deficient or anemic? If so, when and what treatment?

16. If your hair has been breaking off, please answer the following questions:
    a) How frequently do you shampoo your hair?
    b) Do you blow it dry using a brush to style?
    c) Do you permanent wave your hair and/or color treat your hair? If so, how frequently?
    d) If you are African-American, do you permanently straighten, hot comb or press your hair? If so, how frequently?

17. For women:
    a) Do you take birth control pills? If so, what brand and dosage?

b) Do you menstruate? If so please describe frequency, duration and flow.

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c) What is your pregnancy history?

____

d) Do you have excessive hair on your chin, face, chest, around the nipples, legs or abdomen? (please circle)

e) Do you have acne, oily skin or dandruff? (please circle)

f) Are you post-menopausal? _____ If so, at what age? ______ Natural or Surgical? (please circle)

g) Are you on estrogen replacement? If so, for how long and on what dose?

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h) Are you on progesterone replacement? If so, for how long and on what dose?

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i) Have you had a hysterectomy? If so, please list date and if the ovaries were removed?

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