Charlottesville Dermatology PLC
600 Peter Jefferson Pkwy, Suite 230 **Tel: 434-984-2400**
Charlottesville, VA 22911 **Fax: 434-984-1147**

Hair Loss Questionnaire

- Take your time filling 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. This is not a good time to perform a skin cancer screening or discuss other skin issues (lesions, acne, rashes, etc.)
- Please bring copies of all lab reports that you have had in the last 12 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 (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. Is your hair coming out (circle one)? "by the roots" or "breaking off in 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.

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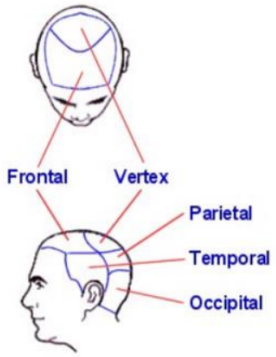
1. Are you SHEDDING excessive numbers of hairs (on your shower, pillow, hairbrush, etc.)? Yes or No

2. Is your scalp hair THINNING gradually over the top? Yes or No

3. List ANY family members with hair thinning, or baldness _____

_____

4. Shade in areas of hair loss on the 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)? 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? How long? _____. How often? _____

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4. Do you use hot combs, press & curl, curling irons 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. 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
- Excess body hair? Yes or No
- Cystic acne? Yes or No

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- Polycystic ovarian syndrome? Yes or No
- Discharge from nipples? 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
- 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, circle: divorce / family illness / cancer / work issues / financial

DON'T FORGET TO BRING COPIES OF ANY LAB REPORTS FROM THE LAST 12 MONTHS