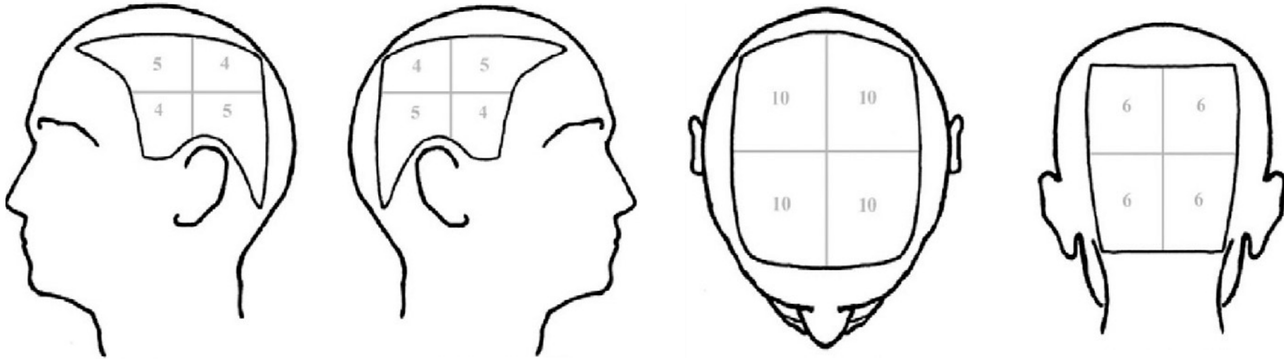
QUESTIONNAIRE: Hair Loss in Women

Name _______________ _Date of birth_ _______________

Race _______________ _Height_ _______________ _Weight_ _______________

Please shade in areas of location of hair loss on the map below:



1. When did you last have a normal head of hair? _______________
2. Was onset of hair loss sudden or gradual? _______________
3. Is your hair coming out "by the roots" or is it breaking off? _______________
4. Is your hair thinning or is it shedding? _______________
5. How often do you wash your hair? _______________
6. What hair products do you use? _______________
7. Do you use hot rollers, ponytails, twists, locks, extensions, or weaves? _______________
   How long? __________ How often? __________
   If you have a weave, is it sewn in or glued? _______________
8. Do you use hot combs, press and curl, curling irons or otherwise apply direct heat to your hair? _______________
9. What type of hair chemicals do you use for your hair? _______________
   Hair dye? _____ Name: __________
   Relaxer? _____ Name: __________ Contain lye? __________
10. Do you have a permanent weave? Name? _______________
    How long? __________ How often? __________
11. Does your scalp itch? Little ☐ Moderate ☐ A lot ☐
12. Do you have seborrheic dermatitis? Yes ☐ No ☐
13. Do you get sores in your scalp? Yes ☐ No ☐
14. What medications are you allergic to? _______________
15. What medications do you take? _______________
16. What herbs or supplements do you take? _______________
17. If you are on birth control pills, which one? _______________
    Have you recently started? __________ When? __________
    Or recently stopped? __________ When? __________

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18. Are you on any other type of hormone treatment? ______________________
    Which one? ______________ How long? ______________
    Or stopped? ______________ When? ______________
19. If applicable, are your menstrual periods regular? ________ Normal flow? ________
    If not, what is happening? How long? ________
20. Have you gone through menopause? ________ Age? ________
21. Are you on any type of weight loss diet? ______________________
22. Are you on a low protein diet? ______________________
23. Are you a vegetarian, if so type? ______________________
24. Any hair loss in men in your family? ________ Baldness? ______________
25. Any hair loss in women in your family? ________ How thin? ______________
26. Any family history of thyroid disease, anemia, or lupus? ______________________
27. What medical problems do you have? ______________________
28. Do you have?

Severe headaches	☐ Yes	☐ No	Discharge from breast	☐ Yes	☐ No
Double vision	☐ Yes	☐ No	Deepening of voice	☐ Yes	☐ No
Excess facial hair	☐ Yes	☐ No	Enlargement of clitoris	☐ Yes	☐ No
Excess body hair	☐ Yes	☐ No	Polycystic ovary disease	☐ Yes	☐ No
Cystic acne	☐ Yes	☐ No			

Have you had in the past 3-12 months?

High fever	☐ Yes	☐ No	Low protein diet	☐ Yes	☐ No
Childbirth	☐ Yes	☐ No	Low iron in blood	☐ Yes	☐ No
Severe infection	☐ Yes	☐ No	Severe psychological stress	☐ Yes	☐ No
Flare of chronic illness	☐ Yes	☐ No	Start/stop birth control pills	☐ Yes	☐ No
Major surgery	☐ Yes	☐ No	Start/stop hormone treatment	☐ Yes	☐ No
Over/under active thyroid	☐ Yes	☐ No	Start/stop beta blocker	☐ Yes	☐ No

29. Do you see a rash in your scalp or on your face? ______________________
    If yes, please describe: ______________________
30. Treatments previously tried (Rogaine, Vitamins, Shampoos, etc)?

____
____
____
____

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