



Hair Loss Questionnaire

NAME _____

DATE _____

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? _____
What did you notice at that time? hair "coming out" or shedding hair looked thinner on scalp
other _____

2. Have you recently noticed that your hair loss was worsening? YES NO
If yes, when did you begin to notice it was worsening? _____
What makes you think it is 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	has (or had) many bald spots
Father					
Mother					
Brother					
Sister					

4. Have you been pregnant at any time before or after the hair loss? YES NO
If yes, when did the pregnancy end? _____

5. Have you had a serious illness at any time before or during the hair loss? YES NO
If yes, please describe the illness and state when it occurred

6. Have you been hospitalized at any time before or during the hair loss? YES NO
If yes, why were you hospitalized and when did you leave the hospital? _____



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7. Have you been under a severe amount of stress at any time before or during the hair loss? YES NO

If yes, when did it start and end? _____

8. Have you started any special diets at any time before or during the hair loss? YES NO

9. Are you a vegetarian? YES NO

10. Please list the names of all the medications you are currently taking in the space below:

Check 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 that you are no longer taking:

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

13. Are you menopausal? YES NO

If you are menopausal, when did menopause occur? _____

If you are menopausal, were your periods (menses) regular prior to menopause? YES NO

14. If you are not menopausal, do you get your menstrual period every month? YES NO

If yes, how often does your period come? every _____ days



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15. Have you ever needed to take birth control pills to make your periods regular? YES NO
16. Do you have unwanted or excessive hair growth on your body? YES NO
Where is the unwanted excessive hair growth located? _____
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17. Do you have hair loss anywhere else on your body? YES NO
Where (other than the scalp) is the hair loss located? _____
18. Do you have any abnormal fingernails or toenails? YES NO
If yes, please describe the problem _____
19. How often do wash/shampoo your hair? every _____ days
20. How often is your hair chemically processed or straightened (relaxers, Japanese straightening, other)?
Never Once a week Once every 2-3 weeks Once every 1-2 months
A few times a year
21. How often is your hair heat processed or straightened (e.g. blowdrying/flat ironing, curling iron)?
Never Once a week Once every 2-3 weeks Once every 1-2 months
A few times a year
22. How often is your hair dyed, highlighted or otherwise color treated?
Never Once a week Once every 2-3 weeks Once every 1-2 months
A few times a year
23. Please check all hair styling practices that you have done in past:
braiding weaves tight hairstyles (e.g. ponytails)
other _____
24. Have you had a biopsy of your scalp to evaluate your hair loss problem? YES NO
25. Have you had blood tests done to evaluate your hair loss problem? YES NO
What tests were done? _____



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26. Have your hormones ever been checked to evaluate your hair loss problem? YES NO
If yes, when? _____
What was the result? _____

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

28. Have you ever been treated with thyroid hormone? YES NO
When? _____

29. Have you been told by a doctor that you have a low iron level? YES NO
When? _____

30. Do you (or a family member) have any autoimmune diseases? YES NO
Check all that apply:

- | | | | |
|----------------------|------|---------------|-------|
| Lupus | self | family member | _____ |
| Rheumatoid arthritis | self | family member | _____ |
| Celiac disease | self | family member | _____ |
| Type 1 diabetes | self | family member | _____ |
| Sjogrens disease | self | family member | _____ |
| Vitiligo | self | family member | _____ |
| Other _____ | self | family member | _____ |

31. Do you have symptoms on the scalp (e.g. itching, pain, burning)? YES NO
If yes, indicate which symptom(s) has occurred (please check all that apply)

- itching tenderness pain burning other _____
- Where on the scalp do the symptoms occur?* the top the sides the back
- temples other _____

32. 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?



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Question 32 cont.

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

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

34. Is there any other important information you would like to share regarding your hair loss?

