Hair Loss Questionnaire

1. How long have you had hair loss? ______________________

2. Since that time, how has your hair loss been? (circle one) BETTER   WORSE   SAME

3. Which part of your head has hair loss?   ALL OVER   FRONT / HAIRLINE   CROWN   BACK / LOWER   OTHER:______________________

4. How rapid was the hair loss?   SUDDEN   GRADUAL

5. 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. Do you feel that you have been shedding excessive numbers of hairs (in the shower, on your hair brush, etc)?  YES   NO

6. Do you feel that your scalp hair is slowly thinning out over the top without losing excessive numbers of hairs daily?   YES   NO

7. Are your hairs (circle one):  BREAKING OFF   or   COMING OUT AT THE ROOTS

8. Within 6 months PRIOR to the onset of hair loss:
   Have you been started on any new medications?   YES   NO
   If YES, please list _______________________________________________
   Have you had any hormone pills or birth control pills started or stopped? __________
   Have you been experiencing any significant medical issues in your life, such as the birth of a child, surgery, illness, or hospitalization? _________________
   Have you been experiencing any significant stress, such as divorce, family illness or cancer, or work issues? _______________________
   Have you had any recent weight loss or change in your diet? _________________

9. Any history of anemia or low iron?  YES   NO;   Are you on any treatment? __________

10. Any history of thyroid disorders?  YES    NO;   Are you on any treatment?____________

11. Are you actively dieting?  YES   NO;  If so, what type of diet? _____________________

12. Are you a vegetarian or vegan?  YES    NO

13. Have you had any recent lab work done to diagnose the hair loss?  YES    NO
   Please include copies of any lab results.

14. Does your scalp itch or sometimes burn or hurt?   YES   NO

15. Do you have a rash or flaking in your scalp?   YES   NO
16. List any family members with hair loss or thinning hair (any grandparents, parents, or siblings)? ________________________________________________________

17. Please list all the prescription medications, supplements, and shampoos/solutions that you have tried for your hair loss:

<table>
<thead>
<tr>
<th>Treatment</th>
<th>When was it tried?</th>
<th>For how long?</th>
<th>Did it help?</th>
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18. Please list the names and dosages of all medications, over-the-counter pills, and hormone pills that you are currently taking and circle the ones that you were taking when your hair began to fall out.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

19. Please list the names and dosages of all vitamins and natural supplements that you are taking and circle the ones that you were taking when your hair began to fall out:

________________________________________________________________________

________________________________________________________________________

20. How often is your hair colored, chemically processed, or straightened?

□ Never  □ Every _____ weeks  □ Every _____ months

21. For Women:

Are your periods:  REGULAR  or  IRREGULAR

Do you have excessive hair on your chin, face, abdomen, or around nipples?  
(circle any that apply)  or  NO

Have you had difficulty becoming pregnant?  YES  NO

Are you postmenopausal?  YES  NO;  At what age? ____________

Have you had a hysterectomy?  YES  NO;  When? ____________

Have your ovaries been removed?  YES  NO;  When? ____________

22. What do you think is the cause of your hair loss? Or, any possible contributing factors?

________________________________________________________________________