STRATICA
DERMATOLOGY

Hair Loss Patient History Form

We take hair loss very seriously due to the large impact it has on a patients' quality of life. We want to ensure that we spend adequate time to address this issue. As part of this, you need to be prepared for your visit. Your visit will only be focused on this condition. Guidelines for a productive visit include:

- Do not shampoo your hair for 1-2 days prior to your appointment
- Bring a picture of your hair when it was not thinning
- Do not comb or brush your hair that morning
- Do not wear nail polish
- Do not bring a bag of hair
- Please be prepared to remove wigs, hair pieces, prostheses, or head coverings so that we can examine your scalp.

Please fill out the hair loss questionnaire to the best of your ability and bring it with you to your appointment. Please use a separate sheet or write on the back if there is not enough room for your answers.

PATIENT INFORMATION

First Name: _____

Last Name: _____

Date of Birth:_____

HISTORY

1. What diagnosis do you think you have? What diagnosis have you been given in the past?

_____

2. How long ago did the hair loss start? _____

3. When was the last time you remembered having a normal head of hair?

_____

4. Circle all that apply:

A) Was the onset of hair loss: SUDDEN or GRADUAL?

B) Do you notice more: SHEDDING, THINNING or HAIR BREAKAGE?

C) Is the hair loss: PROGRESSING, STABILIZNG or STOPPED?

D) Do you notice: PATCHES OF HAIR LOSS or HAIR LOSS ALL OVER THE HEAD?

E) Hair loss is located:

i. TOP OF THE SCALP
ii. BACK OF THE SCALP
iii. SIDES OF THE HEAD
iv. FRONTAL HAIR LINE
v. EYEBROWS
vi. EYELASHES
vii. ARMPITS
viii. GROIN
ix. LEGS
x. OTHERS _____

F) Symptoms experienced include:

i. NO SYMPTOMS
ii. FLAKING
iii. ITCHING
iv. PAIN
v. BURNING
vi. IRRITATION
vii. GREASINESS

G) Are these symptoms: MILD, MODERATE or SEVERE?

H) On the fingernails, do you have any: DIVOTS, RIDGES or DOTS?
I) Do you think you are losing: <100 HAIRS/DAY or >100 HAIRS/DAY?

HAIR CARE

5. How often do you wash your hair?

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6. What hair products do you use in your hair?

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7. Do you use the following? (circle all that apply)
a. HOT ROLLERS
b. PONYTAILS
c. BRAIDS/TWISTS/LOCKS/EXTENSIONS/WEAVES
d. CURLING IRON
e. HAIR DRYERS
f. HAIR DYES/BLEACHES
g. HAIR RELAXERS
h. PERMANENT WAVES
i. None of the above
j. If use any of above, please indicate for how long, and how often:

FOR WOMEN

8. Do you have: (circle all that apply)
a. Additional hair growth on the chin/face/chest/abdomen
b. Deepening of your voice
c. Enlargement of clitoris
d. Abnormal menstrual periods
e. Polycystic ovarian syndrome
f. None of the above

9. Are you in menopause? Yes or No

10. Are you pregnant or contemplating pregnancy in the near future? Yes or No

MEDICAL HISTORY

11. List all known medical conditions:_____

_____

_____

_____

_____

_____

12. Have you been diagnosed with: (circle all that apply)

a. HIV
b. SYPHILIS
c. THYROID DISEASE
d. ANY CANCERS
e. AUTOIMMUNE DISEASES
f. LIVER DISEASE
g. KIDNEY DISEASE
h. HEART DISEASE
i. LOW BLOOD PRESSURE
j. None of the above

13. Do you have? (circle all that apply)

a. SEVERE HEADACHES
b. DOUBLE VISION
c. CYSTIC ACNE
d. DISCHARGE FROM BREASTS
e. AN EATING DISORDER.
f. None of the above

14. Have you had in the last 3-12 months? (circle your answers)

a. HIGH FEVER
b. CHILDBIRTH
c. SEVERE INFECTION
d. FLARE OF CHRONIC ILLNESS
e. MAJOR SURGERY
f. OVER OR UNDER ACTIVE THYROID
g. LOW PROTEIN DIET
h. WEIGHT LOSS
i. LOW IRON IN BLOOD
j. SEVERE PSYCHOLOGICAL STRESS
k. START OR STOP OF BIRTH CONTROL PILLS
l. START OR STOP OF HORMONE TREATMENT
m. START OR STOP OF BETAL BLOCKER MEDICATION
n. None of the above.

15. Do you see a rash in your scalp or on your face? Yes or No

a. If yes, please describe: _____

MEDICATIONS

16. What medications are you taking? _____

17. What supplements are you taking? _____

18. Have you started any new medications or supplements in the last 3-12 months? If so, please name. Yes or No: _____

19. What are your allergies and what is your reaction when exposed to these allergies?

_____

FAMILY HISTORY

20. Which family members have had hair problems (Circle all that apply)

a. Mom/Dad
b. Siblings
c. Children
d. Grandparents

21. Is there a family history of thyroid disease, anemia, autoimmune diseases (such as lupus, vitiligo, type 1 diabetes)? Yes or No

22. Is there a family history of a hormone receptor positive breast cancer? Yes or No

SOCIAL HISTORY

23. Are you a smoker? If so, how many packs/day do you smoke?

_____

24. How much alcohol do you consume in an average week?

_____

25. Are you a long-distance runner? Yes or No

26. Are you on any type of weight loss diet (weight lost to date)? Yes or No

_____

27. Are you a vegetarian (type)? Yes or No

28. What kind of work do you do?_____

29. Do you have an insurance plan that helps cover the costs of your medications?
Yes or No
If so, what is the name of the company? _____

PAST TREATMENTS

30. What have you tried for treatments? (Name, duration, efficacy.)

_____

_____

_____

31. Any side effects from treatments? (i.e. scalp irritation, dizziness, hair growth in unwanted areas, breast enlargement, etc.)

_____

_____

_____

32. What goals or expectations do you have for treatment?

_____

_____

_____