

Dermatology of Seattle

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HAIR LOSS QUESTIONNAIRE

Patient Name: _____

Age: _____ Gender: _____

When did you last shampoo? (Please check one)

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Today | <input type="checkbox"/> Three days ago |
| <input type="checkbox"/> Yesterday | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Two days ago | |

Please check all those that have a YES answer

- | | |
|---|--|
| <input type="checkbox"/> Is the hair coming out at the root? | <input type="checkbox"/> Do you have any totally bald areas? |
| <input type="checkbox"/> Is your hair breaking off? | <input type="checkbox"/> Is the loss slowing down? |
| <input type="checkbox"/> Do you notice excess loss of hair in your comb, on your shoulders, sink or pillow? | <input type="checkbox"/> Is it getting worse? |
| <input type="checkbox"/> Is your hair becoming thin? | <input type="checkbox"/> Have you ever counted the number of hairs you lose daily? If so, what is the average? _____ |
| <input type="checkbox"/> Have others noticed hair loss? | |

Do you:

- | | |
|---|--|
| <input type="checkbox"/> Color? | <input type="checkbox"/> Perm? |
| <input type="checkbox"/> Bleach? | <input type="checkbox"/> Blow Dry? |
| <input type="checkbox"/> Straighten? | <input type="checkbox"/> Hot Comb? |
| <input type="checkbox"/> Do you shampoo daily? | <input type="checkbox"/> Is/was your father's hair thinning or bald? |
| <input type="checkbox"/> What is the name/brand of shampoo that you use?
_____ | <input type="checkbox"/> Is/was your mother's hair thinning or bald? |
| <input type="checkbox"/> Conditioner _____ | <input type="checkbox"/> Is one of your sibling's hair thinning? |
| <input type="checkbox"/> Is your scalp itchy or flaky? | Brother <input type="checkbox"/> Sister <input type="checkbox"/> |
| <input type="checkbox"/> Do you have dandruff? | |
| <input type="checkbox"/> Do you have Psoriasis? | |
| <input type="checkbox"/> Do you wear a wig or hairpiece? | |

In the past six months have you:

- | | |
|--|--|
| <input type="checkbox"/> Have you had a fever over 103°? | <input type="checkbox"/> Had a major surgery?
Describe: _____ |
| <input type="checkbox"/> Had the flu? | |
| <input type="checkbox"/> Been hospitalized? | <input type="checkbox"/> Are you a vegetarian? If yes, what are your protein sources?
_____ |
| <input type="checkbox"/> Had a general anesthetic? | |
| <input type="checkbox"/> Been on a crash diet? | <input type="checkbox"/> Have you had major stress during this time? |
| <input type="checkbox"/> Lost more than two pounds per week? | |