

**Oregon Dermatology and Research Center  
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**Hair Loss Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M or F Date: \_\_\_\_\_

Hair loss generally falls into one of the following categories. If you are experiencing hair loss in patches, please skip to part II on page 3. If you are experiencing diffuse shedding or diffuse thinning, please complete part I.

**Diffuse Shedding** is defined as having excessive numbers of hairs falling out daily. (Please complete part I)

**Diffuse Thinning** is defined as having less hair to cover your scalp, with or without excessive hairs lost each day. (Please complete part I)

**Patchy Loss** is defined as having round or irregular areas of total hair loss, scalp or other hair-except male pattern baldness. (Please complete part II)

**Part I. DIFFUSE SHEDDING OR DIFFUSE THINNING**

*Do you feel you have been shedding excessive numbers of hairs?* (With grooming, brushing, in the shower or tub with shampooing, on your pillow?) Yes or No

*Do you feel that your scalp hair is slowly thinning out over the top without losing excessive numbers of hairs daily?* Yes or No

*Of the above two events, which was the first thing you noticed – shedding or thinning?* \_\_\_\_\_

*Are your hairs* (circle the answers that apply)

- a. Breaking off
- b. Coming out with the root attached (white “club” root at end)

*Approximately how long have you noticed thinning or shedding?* \_\_\_\_\_ years \_\_\_\_\_ months

*Is your hair loss* (circle all the answers that apply)

- a. Diffusely (evenly all over your scalp)
- b. Is most noticeable over the top of your scalp?

*Are you losing hair in areas other than your scalp?* Yes or No *If yes, where* \_\_\_\_\_

*Is there a family history of males with male pattern baldness or thinning?* Yes or No

*Is there a family history of females with thinning over the top of the scalp?* Yes or No

*(In the above questions include grandparents, parents, siblings, children, aunts and uncles.)*

*Please indicate what you eat on an average day. Please include breakfast, lunch, and dinner. We are particularly interested in protein intake.*

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*Past medical history: Please specify if you have had a recent illness, surgery, fever, childbirth, or have been under unusual psychological stress. Please include dates beginning with the most recent.*

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*List all medications you are currently taking or were taking six months prior to beginning your hair loss. Include all prescription medications including hormones (natural and synthetic), birth control pills, and non-prescription medications such as aspirin, Tylenol, Advil, vitamins, herbal and naturopathic medications. Be sure to specify the dosage that you take. If you take vitamin A, include the number of units taken each day. Indicate when each medication was started.*

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*Have you been on a weight loss diet within the last six months? If so, please indicate how much weight was lost and what type of diet you were on.* \_\_\_\_\_

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*Do you have a history of thyroid disease or have you ever taken medication for over or under active thyroid? \_\_\_\_\_ if yes when was it last checked? \_\_\_\_\_*

*Have you ever been iron deficient or anemic? \_\_\_\_\_ if yes when was it last checked? \_\_\_\_\_*

**If your hair has been breaking off, please answer the following questions:**

*How frequently do you shampoo your hair? \_\_\_\_\_*

*Do you blow it dry or use a brush to style? \_\_\_\_\_*

*Do you permanent wave your hair and/or color treat your hair? \_\_\_\_\_ If so, how frequently? \_\_\_\_\_*

*If you are African-America , do you relax, hot comb or press your hair? \_\_\_\_\_ If so, how frequently? \_\_\_\_\_*

**For Women:**

*Are you currently using birth control pills, Depo-Provera or Norplant? If yes, please indicate brand, dosage and start date.* \_\_\_\_\_

*Have you stopped using birth control pills, Depo-Provera or Norplant within the past year? If yes, please indicate stop date.* \_\_\_\_\_

*Do you menstruate? If so, please describe duration and flow. Is your cycle regular?*

\_\_\_\_\_

*What is your pregnancy history?* \_\_\_\_\_

*Do you have excessive hairs on your chin, face, and chest, around the nipples, legs or abdomen?* (please circle all that apply)

*Do you have acne, oily skin or dandruff?* (please circle)

*Are you post-menopausal? If so, what age?* \_\_\_\_\_ *Natural or surgical?* \_\_\_\_\_

*Are you on estrogen replacement? If so, for how long and what dose?* \_\_\_\_\_

*Are you on progesterone replacement also? If so, for how long and what dose?* \_\_\_\_\_

*Have you had a hysterectomy? If so, please indicate date.* \_\_\_\_\_

*Were your ovaries removed?* Yes No

**You may stop here unless you are experiencing hair loss in patches.**

## **Part II. HAIR LOSS IN PATCHES**

They're several types of hair loss occurring in round or extensive irregular patches, usually on the scalp.

Answers to the following questions will assist us in learning more about your type of hair loss.

*What is your ethnic or racial group:* \_\_\_\_\_

*Age of onset:* (When first patch was noticed) \_\_\_\_\_

*Duration of hair loss:* \_\_\_\_\_

*Duration of current episode:* \_\_\_\_\_

*Number of episodes of hair loss, assuming your hair regrew fully in between each episode.* \_\_\_\_\_

*What methods of treatments have you had, and how did your hair loss respond?* \_\_\_\_\_

\_\_\_\_\_

*What is the most extensive hair loss you have ever experienced?* \_\_\_\_\_

*Is hair being actively lost at present?* \_\_\_\_\_

*What sites on your body are affected by hair loss?* Scalp only, eyelashes, eyebrows, pubic area, auxiliary, extremities, beard in men (circle all that apply)

*Are your fingernails normal?* \_\_\_\_\_

*Do you have unusual skin eruptions?* \_\_\_\_\_

*Do you have a history of asthma, eczema or hay fever?* \_\_\_\_\_

*Does anyone in your family have a history of asthma, eczema, or hay fever?* \_\_\_\_\_

*Do you have any autoimmune diseases such as pigment loss (veiling), thyroid disease, lupus, rheumatoid arthritis, scleroderma (hardening of the skin), or insulin-dependent diabetes?* \_\_\_\_\_

*Does anyone in your family have any of the above diseases?* \_\_\_\_\_

*Do you have any idea what triggers the hair loss episodes such as stress, infection, etc?* \_\_\_\_\_

\_\_\_\_\_

*What drugs were you taking when your hair loss began?* \_\_\_\_\_

*Any seasonal variation?* \_\_\_\_\_

*Do you experience itching or tingling of your scalp when hair loss is active?* \_\_\_\_\_

*Is there scaling, redness, pustules or roughness associated with the areas of hair loss?* \_\_\_\_\_

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Thank you for completing the above questionnaire. Your responses will be very helpful during your visit today. If you have additional insight into your hair loss that you would like to include in this questionnaire, please use the space below for comments.