

UDC Hair Diseases Clinic

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 abilities and bring it with you.
 - Please use a separate sheet or write on the back if there is not enough room for your answers

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 applies:
 - 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? _____
6. What hair products do you use in your hair? _____
7. Do you use the following? (circle your answers)
 - 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 your answers)
- 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? Y or N
10. Are you pregnant or contemplating pregnancy in the near future? Y or N

MEDICAL HISTORY

11. What medical issues do you have? _____
12. Have you been diagnosed with: (circle your answers)
- 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 your answers)
- 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?
- 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? Y or N
- 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. Y or N _____
- 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) Y or N
- 22. Is there a family history of a hormone receptor positive breast cancer? Y or N

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? Y or N
- 26. Are you on any type of weight loss diet (weight lost to date)? Y or N _____
- 27. Are you a vegetarian (type)? Y or N _____
- 28. What kind of work do you do? _____
- 29. Do you have an insurance plan that helps cover the costs of your medications? Y or N
 - a. 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? _____

