Elizabeth M. Vennos, M.D.

Patient Name_____ **Date**_____

HAIR LOSS / QUESTIONNAIRE

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When did you FIRST become AWARE of the hair loss?	Month_____ Year_____	
How much hair volume have you lost so far? (If possible, pull your hair back into a ponytail and estimate how much smaller it is.)	100%.....75%.....50%.....25%.....10% (circle one)	
How did the hair loss start?	_____Slowly _____Suddenly	
What areas are losing hair?	_____All over scalp _____Specific areas, Where? _____	
What kind of loss are you experiencing?	_____Shedding (excessive hair falling out daily) OR _____Thinning (less hair covering the scalp)	
Does the hair come out in clumps?	_____No _____Yes	
Where have you noticed more loose hairs?:	_____In my brush or comb _____On my pillow _____In the bathtub or drain. _____I have not noticed more hairs in these areas	
Have you performed a hair count? (A hair count involves saving and counting every hair lost for a 24-hour period on three separate days.)	_____No _____Yes	
Describe your hair loss over the last two weeks.	_____The **same** as when it started. _____The loss is **slowing** down. _____The loss is much **faster** than when it started.	
Have you noticed hair loss in areas other than the scalp?	_____No _____Yes, if so where? ___beard area ___body or limbs ___arm pits ___pubic area	
Have you had? If yes, circle your choice and write the date it was last done.	Permanent wave, Chemical curling, Hair Coloring	
Have you ever had any reaction to a chemical hair treatment?	____No _____Yes. When? _____ _____Irritation, rash _____Broken hairs or falling out	
Since the hair loss started, has your *scalp* been consistently:	_____Tender _____Itchy _____Scaly.	
Have any tests been done to find the cause of your hair loss?	_____No _____Yes, these tests have been done:	
Women: Do you have heavy menstrual periods? Excessive body hair? History of infertility? History of severe acne?	_____No ____Yes _____N/A _____No ____Yes _____No ____Yes _____No ____Yes	
Since the hair loss, have you seen any change in your nails?	_____No _____Yes, please describe:	

TURN OVER >>>>>>

Describe a typical breakfast, lunch and dinner.	Breakfast: Lunch: Dinner:	
Have you tried any treatments for the hair loss?	____No _____Yes, please list all treatments:	
Have you ever had an episode of hair loss in the past?	____No _____Yes, please describe:	
In the last year, have you had any of the following: **(Check all that apply and give details)**	____Hospitalization _____Surgery ____Accident/Trauma _____Severe Illness ____High Fever (Over 102F) _____Child birth ____Personal tragedy/Loss _____Thyroid Disease ____Severe personal stress _____Wt loss diet ____Steroid use, including nasal sprays _____None	
List all medications. Include vitamins, naturopathic supplements, injections, birth control pills, hormones and all prescription and over-the-counter medications. Indicate the **dates** each drug was **started**. (Use separate page if necessary)		
Have you taken any of the following drugs in the past three years?	____Anti-cancer _____Thyroid suppressor ____Blood thinners _____Blood pressure ____Seizure drugs _____Anti-depressants (TCA)	
Have you washed your hair today?	____No _____Yes	
When was your last physical exam?	____Month _____Year	

FAMILY HISTORY of hair loss:

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BLOOD RELATIVE	**PRESENT AGE (or age when deceased)**	**DID/DO THEY HAVE HAIR LOSS DURING THEIR LIFETIME?**	**APPEARANCE OF HAIR NOW (or at end of life.) E.g. thinning, baldness, etc.**	
FATHER:		____No _____Yes		
MOTHER:		____No _____Yes		
SISTERS:	1. 2.	____No _____Yes ____No _____Yes ____No _____Yes		
BROTHERS:	1. 2. 3.	____No _____Yes ____No _____Yes ____No _____Yes		
Any aunts or uncles with hair loss?	Who?			

Please add any other information you think may be helpful regarding your hair loss:

_____

_____

_____