

HAIR LOSS QUESTIONNAIRE (WOMEN)

Name: _____ Age: _____

Shedding is defined as having excessive numbers of hairs falling out daily.

Thinning is defined as having less hair to cover scalp, with or without excessive hairs lost each day.

1. Do you feel you have been **shedding** excessive numbers of hairs? (In the shower, the tub, on your hair brush, on the counter, or on your pillows)?
2. Do you feel that your scalp hair is **slowly thinning out** over the top without losing excessive numbers of hairs daily?
3. Are your hairs-
 - a. **breaking off or**
 - b. **coming out with the roots attached** (with a white “club” root at the end)?
 - c.
4. Approximately **how long** have you noticed thinning or shedding?
5. Is your hair being lost-
 - a. **in patches**
 - b. **diffusely** (evenly all over scalp)?
 - c. or is it **most noticeable over the top** over the scalp?
6. Are you losing hair in other **areas other than your scalp**?
7. Is there a **family history of males** with male pattern baldness? **Family history of females** with thinning over the top of the scalp? Anyone with **patchy hair loss**?
8. Is there any **personal or family history of allergies** such as hay fever, asthma or eczema?
9. Please indicate **what you eat** on an average day. Please include breakfast, lunch and dinner. We are particularly interested in protein intake.
10. **Past medical history.** Please specify if you have had a recent illness, surgery, fever, childbirth, or have been under psychological stress. Please include dates beginning with the most recent.
11. **List all medications** you are currently taking or have taken within the past six months. Include all prescription medications, aspirin, Tylenol, Advil, vitamins, hormones and birth control pills. Be sure to specify the dosage that you take. If Vitamin A is taken, include the units taken each day.

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12. Have you been on a weight-loss diet within the last six months? If so please indicate how much weight was lost and what diet you were on?
13. Do you have a history of thyroid disease or have you ever taken medication for over or under-active thyroid?
14. Have you ever been iron deficient or anemic?
15. If your hair is breaking off, please answer the following questions:
- How frequently do you shampoo your hair?
 - Do you blow it dry using a brush or style?
 - Do you permanent wave your hair and/or color treat your hair? If so how frequently?
 - If you are African American, do you permanently straighten, hot comb press your hair?

16. For women:

Do you take birth control pills? If so what brand and dosage?

Do you menstruate? If so, please describe duration and flow?

What is your pregnancy history?

Do you have excessive hair on your chin, face, and chest around the nipples, legs or abdomen? (please circle).

Are you post menopausal?

If so, at what age?

Are you on estrogen replacement what dose?

If so, for how long and at

Have you had a hysterectomy? ovaries were removed.

If so. Please list date and if

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