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Name _____

Date _____

HAIR LOSS QUESTIONNAIRE

1. When did you first notice that you were losing your hair? _____
What did you see? Hair "coming out"/shedding Hair looked thinner on scalp
 Other: _____

2. Have you lost any of the hair in your eyebrows? Yes No

3. Have you lost any hair on the rest of your body? Yes, where _____ No

4. Is hair loss worsening? Yes No
When did this start? _____
What makes you think it is worsening? _____

5. Tell us about hair loss in your family members (check all that apply)

	Has a lot	Some thinning	Some balding	Many bald spots
Father				
Mother				
Brother				
Sister				

6. Were you pregnant at any time before or during the hair loss? Yes No
When did the pregnancy end? _____

7. Have you been seriously ill at any time before or during the hair loss? Yes No
If yes please describe what and when _____
Were you hospitalized during the time you experienced hair loss? Yes No
If yes, explain _____

8. Any severe stress during time of hair loss? Yes No
If yes please explain _____

9. Have you tried any special diets during this time or had weight loss or gain?

10. Please list medications you take. Put a check next to any you were taking when your hair started to fall out.

11. Please list other medications you were taking when your hair began to fall out that you are no longer taking:

12. Please list vitamins or supplements: _____

13. For women: Are you menopausal? Yes No
If yes, when did this occur _____.
Were cycles regular before menopause? Yes No
If not menopausal, are your cycles regular? Yes No

14. For women: did you ever use birth control pills to make your periods regular? Yes No

15. For women: do you have unwanted or excessive hair growth elsewhere on your body? Yes No
If yes, where? _____

16. How often do you shampoo? Every _____ days. Last shampoo _____

17. How often do you chemically process or straighten your hair (relaxers, other)?
 Never Once a week Once every 2-3 weeks
 Once every 1-2 months A few times a year

18. How often do you use heat process or straighten your hair (i.e. Blow dry/flat iron/curling iron)?
 Never Once a week Once every 2-3 weeks
 Once every 1-2 months A few times a year

19. How often is your hair dyed, highlighted, or other color treatment?
 Never Once a week
 Once every 2-3 weeks Once every 2-3 months

20. What types of styling practices have you done in the past?
 Braiding Weaves
 Tight hairstyles (ponytails) Other: _____

21. Do you have symptoms in your scalp? Yes No
If yes, which? Itch Tenderness Pain Burning Other: _____
Where on your scalp do you feel these symptoms? _____

22. Have you ever had a scalp biopsy? Yes No

23. Have you had blood tests to check for reasons for hair loss? Yes No

24. Have hormones been checked? Yes No

25. Have you ever had a thyroid condition? Yes No

26. Have you ever taken thyroid medication? Yes No

27. Have you ever been anemic (low iron)? Yes No

28. Have you ever had a low vitamin D level? Yes No

29. Is there a family history of autoimmune disease? Yes No

	Self (check all that apply)	Family Member (state their relationship to you)
Lupus		
Rheumatoid Arthritis		
Fibromyalgia		
Vitiligo		
Alopecia Areata		
Pernicious Anemia		
Celiac Disease		
Type 1 Diabetes		
Other:		

30. What prescription and over the counter treatments have you tried for your hair loss and did they help?
How long did you use them?

31. What do you think is the cause for your hair loss

32. Would you like to provide any other information regarding your hair loss?
