Hair Loss Intake Forms

ONSET OF HAIR LOSS

1. How many months or years has it been since you had a normal hair density? _____
2. Was the onset of hair loss sudden or gradual? _____
3. Is your hair coming out “by the roots” or is it breaking off? _____
4. In 24 hours, do you estimate you lose more or less than 100 hairs? _____
5. Is this the first and only time you have experienced hair loss? _____
6. Where have you noticed hair loss
    a. Top/front of scalp: □ Yes □ No
    b. Sides of scalp: □ Yes □ No
    c. Back of scalp: □ Yes □ No
    d. Armpits: □ Yes □ No
    e. Groin: □ Yes □ No
    f. Eyebrows: □ Yes □ No
    g. Eyelashes: □ Yes □ No
7. Do you have a theory as to why you are experiencing hair loss? _____

_____

HAIR CARE PRACTICES

1. How often do you wash your hair per week?
2. What hair products do you currently use
    a. Shampoo: _____
    b. Conditioner: _____
    c. Other hair products:_____
3. Do you use ponytails, braids, twists, locks, extensions, or weaves? _____
4. Do you use blow dryer, hooded dryer, hot combs, press and curl, straightening or curling irons or otherwise apply direct heat to your hair? _____
5. What type of hair chemicals do you use for your hair (hair dye, relaxers, ect.)? _____

_____

SYMPTOMS

1. Does your scalp experience any of the following?
    a. Itching □ Yes □ No
        i. If yes, rate the itch from 1-10:
    b. Tender or Painful □ Yes □ No
        i. If yes, rate the pain from 1-10:
    c. Crawling sensation □ Yes □ No
    d. Sensitive or Irritated □ Yes □ No
    e. Flaking □ Yes □ No
    f. Greasy □ Yes □ No
    g. Redness □ Yes □ No
    h. Bumps or sores □ Yes □ No
2. Do you see a rash in your scalp or on your face? _____
    a. If yes, please describe:_____
3. Do you have any divots/impressions/dots or ridges on your nails?

RELEVANT MEDICAL HISTORY

1. Do you have?
    a. Psoriasis □ Yes □ No
    b. Dandruff □ Yes □ No
    c. Severe headaches □ Yes □ No
    d. Excess facial hair □ Yes □ No
    e. Excess body hair □ Yes □ No
    f. Cystic Acne □ Yes □ No
    g. Discharge from breast □ Yes □ No
    h. Deepening of voice □ Yes □ No
    i. Enlargement of clitoris □ Yes □ No
    j. Anemia □ Yes □ No
    k. Polycystic ovary disease □ Yes □ No
    l. Anxiety □ Yes □ No
    m. Depression □ Yes □ No
2. DId you experience any of the following 3-12 months prior to the onset of the hair loss?
    a. High fever □ Yes □ No
    b. Weight loss or gain > than 10 lbs □ Yes □ No
    c. Childbirth □ Yes □ No
    d. Severe infection □ Yes □ No
    e. Flare of chronic illness □ Yes □ No
    f. Major surgery or general anesthesia □ Yes □ No
    g. Thyroid disease □ Yes □ No
    h. Low protein diet □ Yes □ No
    i. Low iron in blood □ Yes □ No
    j. Severe psychological stress □ Yes □ No
    k. Start or stop birth control pills □ Yes □ No
    l. Start or stop hormone treatment □ Yes □ No
    m. Start or stop beta blocker medication □ Yes □ No
3. What medications are you allergic to? _____
4. What medications do you take? _____
5. Do you use oils, herbs, or supplements either topically or orally? _____
    a. List the names of products: _____
6. Have you recently started, stopped, or changed brands of birth control including oral or implantable methods? _____
7. List the name as well as the start and stop dates of any prior birth control methods:
    a. Start Date: End Date: Name:
    b. Start Date: End Date: Name:
    c. Start Date: End Date: Name:
8. Are you on any other type of hormone treatment?
    a. Start Date: End Date: Name:
    b. Start Date: End Date: Name:
9. If applicable, are your menstrual periods regular? _____
    a. If not, what is abnormal?
    b. Light, normal or heavy flow?
    c. How many days between periods?
    d. How many days does the period last

10. If applicable, have you gone through menopause? _____
    a. Age?
11. Are you on any type of weight loss diet or medication? _____
12. Are you on a low protein diet? _____
13. Are you a vegetarian,vegan or other type of diet? _____
14. Are you following any other dietary restrictions (gluten free, ect)? _____
15. Any hair loss in men in your family? _____
    a. If yes, please state their relation to you (father, grandfather, uncle, son):
    _____
    b. Anyone with complete baldness? _____
    c. Does their hair loss appear similar to yours? _____
16. Any hair loss in women in your family? _____
    a. If yes, please state their relation to you (mother, grandmother, aunt, daughter):
    _____
    b. Does their hair loss appear similar to yours? _____
17. Any family history of thyroid disease, anemia, polycystic ovarian disease, or lupus?
    _____
18. Any personal or family history of breast or ovarian cancer? _____
    a. If yes, please state their relation to you: _____

TREATMENT

1. Have you seen another doctor for this problem? _____
    a. If yes, was lab testing performed? _____
        i. *Results must be brought to your visit or sent before your visit*
    b. If yes, was a biopsy performed? _____
        i. *Results must be brought to your visit or sent before your visit*
    c. Please also bring ONE printed photo of your hair when you were younger 2.

Are you using topical Rogaine/Minoxidil? _____
    a. If yes, strength (2 or 5%): _____
    b. How often (once or twice a day) _____
    c. Are you consistent with use? _____
    d. How long have you used it? _____
    e. Did it work? _____
    f. Did it cause more hair to fall out in the beginning? _____
    g. Any side effects? _____

3. Are you using ora Minoxidil? _____
    a. If yes, strength (1.25 mg/2.5 mg)): _____
    b. How often (once or twice a day) _____
    c. Are you consistent with use? _____
    d. How long have you used it? _____
    e. Did it work? _____
    f. Did it cause more hair to fall out in the beginning? _____
    g. Any side effects? _____
4. Are you using anything else to treat your hair loss? _____
    a. Biotin? _____
        i. If yes, dose: _____
    b. Spironolactone/aldactone? _____

i. If yes, dose: _____

c. Shampoo and/or conditioner system formulated for hair loss (include name)? _____

d. Finasteride/Propecia?_____

i. If yes, dose: _____

e. Dutasteride? _____

i. If yes, dose: _____

f. LED light helmets or other light therapy? _____

g. Ketoconazole/Nizoral shampoo? _____

h. Antibiotics (doxycycline, clindamycin, benzoyl peroxide)? _____

i. Prior scalp injections?_____

i. If yes, estimate total number of prior office visits where injections were performed:_____

ii. Were the scalp injections made from PRP, PRF, steroids or something else? _____

j. Iron supplements?_____

k. Other vitamins (list:) _____

5. Please list any and all treatments you have tried for hair loss/hair growth and including medications, topicals, vitamins and OTC products:

a. Start Date:	End Date:	Name:
b. Start Date:	End Date:	Name:
c. Start Date:	End Date:	Name:
d. Start Date:	End Date:	Name:
e. Start Date:	End Date:	Name:
f. Start Date:	End Date:	Name:

6. Any side effects from previous or current treatments (scalp irritation, dizziness, hair growth in unwanted areas, breast enlargement, etc)? _____

7. Has any treatment helped more than others (explain)? _____

TREATMENT EXPECTATIONS

What goals or expectations do you have for treatment?

_____

WHAT TO BRING TO YOUR VISIT

- Printed copy of all lab results from the last 12 months
- Biopsy report of scalp if you've had a scalp biopsy
- One photograph of your baseline hairline
- Do not wash your hair for 48 hours prior to your appointment