

## HAIR QUESTIONNAIRE

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

**Shedding** is defined as having excessive numbers of hair 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 shower or tub, brush, on counter, on pillow)
  
2. Do you feel that your scalp hair is slowly thinning out over the top without losing excessive numbers of hair daily?
  
3. Of the above two events, which was the first thing you noticed shedding or thinning?
  
4. Are your hairs
  - (a) Breaking off or
  - (b) Coming out with the roots attached (with a white "club" root at the end)?
  
5. Approximately how long have you noticed thinning or shedding?
  
6. Is your hair being lost (a) in patches? b) diffusely (evenly all over scalp)? (C) or is it most noticeable over the top of the scalp?
  
7. Are you losing hair in areas other than your scalp?
  
8. 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?  
In all of the above questions include grandparents, parents, siblings, children, aunts, and uncles.
  
9. Is there any personal or family allergies such as hayfever, asthma or eczema?  
  
Is there any personal or family autoimmune diseases such as early onset diabetes, loss of skin pigment, rheumatoid arthritis, or thyroid disease?
  
10. Please indicate what you eat on an average day. Please include breakfast, lunch and dinner. We are particularly interested in protein intake.

11. Past medical history. Please specify if you have had a recent illness, surgery, fever, childbirth, or have been under psychologic stress. Please include dates beginning with the most recent.
12. List all medications you are currently taking or have taken in the last 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.
13. Have you been on a weight-loss diet within the last six months? If so please indicate how much weight was lost and what type of diet you were on.
14. Do you have a history of thyroid disease or have you ever taken medication for over-or under-reactive thyroid?
15. Have you ever been iron deficient or anemic?
16. If your hair has been breaking off, please answer the following questions:
  - (a) how frequently do you shampoo your hair?
  - (b) Do you blow it dry using a brush to style?
  - (c) Do you permanent wave your hair and/or color treat your hair? If so, how frequently?
  - (d) If you are African-American, do you permanently straighten, hot comb or press your hair? If so, how frequently?
17. For women:

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

Do you menstruate? If so please describe the duration and flow.

What is your pregnancy history?

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

Do you have acne, oily skin or dandruff? (please circle)

Are you post menopausal? If so, at what age? \_\_\_\_\_  
Natural or surgical?

Are you on estrogen replacement? If so, for how long and what dose?

Are you on progesterone replacement also? If so, for how long and what dose?

Have you had a hysterectomy? If so please list date and if ovaries were removed.