**Dermatology Consultants of Marin**
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## PATIENT HAIR LOSS EVALUATION

(Please circle or indicate your answer)

1. What is your specific hair complaint? (Check)

| | | | | | |
|---|---|---|---|---|---|
| Hair Shedding | | Hair Thinning | | Hair Breaking | |
| Not Growing | | Excess Hair | | Loss of body hair | |

2. How long has the current episode of hair loss been? _____

3. How much hair do you think you have lost? (Circle)
   a. E.g. How much has your ponytail diameter shrunk?

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 10% | 20% | 30% | 40% | 50% | 60% | 70% | 80% | 90% | 100% |

4. Is the hair loss getting worse or is it stable now? _____

5. Have you had previous episode(s) of hair loss? Yes No

6. How old were you when you first started losing hair? _____

7. Where is most of your hair loss? (Circle)

| | | | | |
|---|---|---|---|---|
| Front Scalp | Back Scalp | Side of Scalp | Everywhere | Bald Patches |

8. Do you have any associated scalp symptoms? (Circle)

| | | | | | | |
|---|---|---|---|---|---|---|
| Itching | Burning | Pain | Flaking | Bumps | Pimples | Other: |

***Hair Care Practices***

9. Your natural hair color:

| | | | | | | |
|---|---|---|---|---|---|---|
| Black | Dark Brown | Light Brown | Blonde | Red | White | Gray |

10. Your natural hair texture:

| | | |
|---|---|---|
| Straight | Curly | Wavy |

11. Your Past Hair Care:

| | | | | | |
|---|---|---|---|---|---|
| Perm | Straightening | Coloring | Blow Dryer | Hot Iron | Hot Rollers |

Previous treatments for hair loss used:

_____

_____

_____

| | | | |
|---|---|---|---|
| Date of your last shampoo: | | Frequency of shampooing: | |

| | |
|---|---|
| Shampoo Used: | |

**Relevant Immediate Past History:** (*last 6 months only)* (please check correct answer)

| Trigger | √ | Details & Dates |
|---|---|---|
| Serious illnesses/infections | | |
| Hospitalizations/surgery | | |
| Emotional Stress | | |
| Vaccinations | | |
| Chemical Hair Treatments | | |
| Crash Dieting/ Loss if Weight (How much & over how long?) | | |
| New or Change in Medication dose | | |
| Other | | |

| Dietary History | Yes | No | Details |
|---|---|---|---|
| Are you a vegetarian? | | | |
| Do you eat meat? How often? | | | |
| Do you take a multivitamin? | | | |
| Do you exercise? How often? | | | |

| Females Only | Yes | No | Details |
|---|---|---|---|
| Are you pregnant or breast feeding? | | | |
| Date of last pregnancy? | | | |
| Is your menstrual bleeding regular? | | | Every ____ days. Lasts ____ days.<br>Light Medium Heavy |
| What is your birth control method? | | | |
| Have you started, stopped, or changed birth control pills or hormone replacement therapy in the last 6 months? | | | |
| Do you have menopausal symptoms? (Hot flashes, change in weight, vaginal dryness?) | | | |

**Current Medications (within the last 6 months):**
*(Include all vitamins, herbal and over the counter items)*

| Name of Drug | Dose | Frequency | Start Date | End date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Allergies:** *(Please List)*

| |
|---|
| |
| |
| |
| |

**Family History:** Is there a family history of the following?

| | Yes | No | Details *(list family member: siblings, parents, grandparents only)* |
|---|---|---|---|
| Hair loss or thinning | | | |
| Excess unwanted body/ facial hair | | | |
| Diabetes | | | |
| Loss of skin pigment (vitiligo) | | | |
| Thyroid disorder | | | |
| "Hairy" Women or Men | | | |
| Infertility | | | |
| Cancer | | | |
| Lupus or Rheumatoid Arthritis | | | |
| Other | | | |

**Social History:** Do you or have you ever smoked? Yes No

| **Do you have any of the following? :** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Acne | | Anemia | | Heart Disease | | Ovarian Cancer | |
| Greasy Skin | | Heat/ Cold intolerance | | Celiac Disease | | Uterine Cancer | |
| Psoriasis | | Tremors | | Lupus Erythematosus | | Abnormal Moles | |
| Asthma | | High Blood Pressure | | Ulcerative Colitis | | Abnormal Scar/Keloids | |
| Hay Fever/ Sinusitis | | High Cholesterol | | Bowel Cancer | | Aids/ HIV + | |
| Excessive fatigue | | Diabetes | | Breast Cancer | | Down Syndrome | |
| Other: (List): | | | | | | | |