Associated Dermatologists

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HAIR LOSS QUESTIONAIRE

•Take your time filling this form. Check your calendar for exact timing for your answers. Include every detail and BE HONEST!
•Your entire appointment will be dedicated to your hair loss. We will not be doing a skin cancer screening or discussing other skin issues (lesions/moles, acne, rashes, hives, etc.)
•Please bring copies of all lab reports that you have had in the last few (2-3) months.
•Please bring a complete list of current medications with the duration you have been on them, and any change in dosage.

Name: ____ Date:________________
Age: ________ Height: ________ Weight: ________ Race/Ethnicity:_______________________

YOUR HAIR HISTORY:

1. When did you last have a “normal” head of hair?

____

2. How rapid was your hair loss (circle one)? Sudden or Gradual
3. How long have you had “hair loss?”____
4. How has your hair loss been since it started (circle one)? Better Worse Same
5. Is your hair coming out (circle one)? “by the roots” or “breaking off in middle”

***SHEDDING**=an excessive numbers of hairs falling out daily (normal loss is ~100 hairs per day)
***THINNING**= having less hair to cover the scalp, with or without excess hairs lost each day.

1. Are you SHEDDING excessive numbers of hairs (on your shower, pillow, hairbrush, etc.)? Yes or No
2. Is your scalp hair THINNING gradually over the top? Yes or No
3. List **ANY** family members with hair thinning, or baldness ______________________________

____

4. Do you feel like your front hairline has moved back? Yes or No
5. Does your scalp itch (circle)? None / Mild / Moderate / Severe
6. Does your scalp burn or hurt? Yes or No
7. Do you get bumps or sores in your scalp? Yes or No
8. Do you have rashes (redness or flaking) in your scalp? Yes or No. If yes, please describe

____

9. Shade in areas of hair loss on the diagram AND circle below:

Circle areas affected: Frontal / Hairline / Vertex / Temporal / Parietal / Occipital / ENTIRE SCALP

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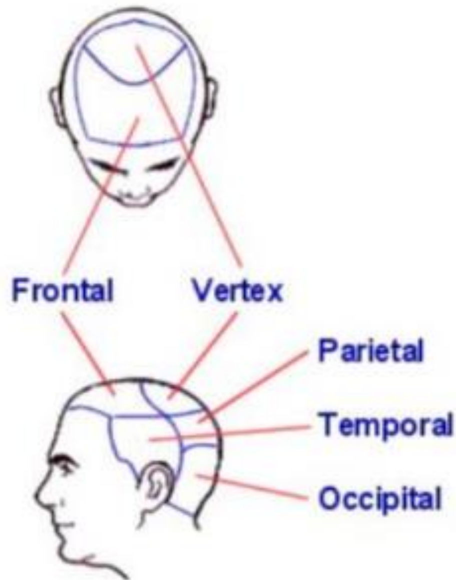
Updated: December 2024



HAIR CARE HISTORY:

1. How often do you wash your hair? ____
2. What hair products do you use for regular maintenance (shampoo, conditioner, hair gel, mousse, spray)? ____
3. Do you use (circle)? Hot rollers, ponytails, braids, twists, locks, extensions, weaves? How long? ____________________. How often? ______________________________________
4. Do you use hot combs, press & curl, curling irons or otherwise apply direct heat to your hair?
____
5. What type of hair chemicals do you use on your hair (circle)? Hair dye, Permanent wave, Relaxer? How long? ____________________ How often? ______________________________
6. Any scalp surgery, face lift, or brow lifts? ____
7. List ALL special treatments or medications you use for your scalp or hair?
____

MEDICAL HISTORY:

*Most important: Did your hair issues begin after any change in medications, supplements, hormones?

1. Medications (**ALL** prescriptions AND over the counter) *please attach list with start dates
2. Supplements, Herbs, Vitamins, Essential Oil: ______________________________________
3. Any hormone treatment (includes ANY birth control) _______________________________
4. Have you stopped or started any hormone? ____
5. Do you have menstrual periods? Yes or No. Is it regular? Yes or No
   If not, what is happening? ____
6. Have you gone through menopause? Yes or No. Age of menopause? ___________________
7. Have you had difficulty becoming pregnant? Explain ____________________________________
   Hysterectomy? Yes or No.

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Do you still have ovaries? Yes or No. If No, when removed? ______________________

8. What major medical problems do you have? ______________________________________

9. Do you have?
   - Excess facial hair? Yes or No
   - Excess body hair? Yes or No
   - Cystic acne? Yes or No
   - Polycystic ovarian syndrome? Yes or No
   - Discharge from nipples? Yes or No

10. Have you had in the last 12 months?
   - Weight loss? Yes or No. How much? __________
   - Dramatic change in diet? Yes or No. Circle: Vegetarian / Vegan / Keto
   - Childbirth? Yes or No
   - High fever? Yes or No
   - COVID or Flu? Yes or No
   - Severe infection? Yes or No
   - Flare of chronic illness? Yes or No
   - Any Surgery? Yes or No
   - Over or under active thyroid? Yes or No
   - Anemia or low iron? Yes or No
   - Start/stop birth control pills? Yes or No
   - Start/stop hormone replacement? Yes or No
   - Start/stop beta blocker medication for high blood pressure or heart disease? Yes or No
   - Severe psychological stress? Yes or No. If yes, circle: divorce / family illness / cancer / work issues / financial/ other

*****DON'T FORGET TO BRING COPIES OF ALL LAB REPORTS FROM THE LAST FEW MONTHS AS WELL AS A LIST OF ALL YOUR MEDICATIONS & THE DURATION OF EACH*****