Name: ________________________ Date:________________________

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HAIR LOSS PROFILE

Please tell me more about your hair loss condition by answering the following questions. Some questions will require a YES or NO marking. For other questions please use the space provided to write your answers in the spaces provided.

1. When did you FIRST notice that you were losing your hair?_______________________________

   What did you notice at that time? ☐ Hair "coming out" or shedding ☐ Looked thinner on scalp

   ☐ Other:____

2. Have you noticed that your hair loss was worsening? ☐ YES ☐ NO
   If yes, when did you begin to notice it was worsening? ___________________________________
   What makes you think it was worsening?____
3. Please mark the box that best describes your family history of scalp hair.
   (If you have more than one sibling per gender, mark the box for the least amount of hair present for them)

	Has hair	Some thinning	Small bald area	Large bald area	bald spots
Father	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐

4. Have you been pregnant at any time before or during the hair loss? ☐ YES ☐ NO
   If yes, when did the pregnancy end?____

5. Have you had a serious illness at any time before or during the hair loss? ☐ YES ☐ NO
   If yes, describe please:____
   ____

6. Have you had any hospitalizations before or during the hair loss? ☐ YES ☐ NO

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7. Have you been under a severe amount of stress at the time before or during the hair loss? ☐ YES

   If yes, when did it end?____ ☐ NO

8. Any special diets during this time? ☐ YES ☐ NO
9. Are you a vegetarian? ☐ YES ☐ NO

10. Please list all medications you are currently taking in the space provided. Check any that you were taking at the time of the hair loss.

☐ ____
☐ ____
☐ ____
☐ ____
☐ ____

11. Please list any additional medications that you may or may not still taking:

____
____
____
____

12. Please list any vitamins or natural products that you are currently taking:

____
____
____
____

13. Menopausal? ☐ YES ☐ NO
    If yes, when did it occur?____
    If you are menopausal, were your periods regular prior to menopause? ☐ YES ☐ NO

14. If you're not menopausal, do you get regular menstrual every month? ☐ YES ☐ NO

15. Have you ever used birth control?_______________________

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16. Do you have unwanted or excessive hair growth on your body?____________________

17. Have you experienced hair loss anywhere else on your body?_______________________________

18. Do you have excessive dryness or breakage in your fingernails or toenails?___________________

19. How often do you shampoo your hair? Every __________ Days

20. How often is your hair chemically process or straightened?

    ____Never _____Once a week ____2-3 wks ____1-2 mths ____2x year

21. How often is your hair mechanically straightened? (blow drying, flat ironing, curling iron)

    ____Never _____Once a week ____2-3 wks ____1-2 mths ____2x a year

22. How often is your hair dyed, highlighted, or color treated?

    ____Never _____Once a week ____2-3 wks ____1-2 mths ____2x a year

23. Please check all the hair styling practices that you have done in the past

    ____Braiding ____Weaves _____Tight hairstyles _____Other

24. Have you ever had a biopsy performed of your scalp by a dermatologist? ☐ YES ☐ NO

25. Have you had blood tests performed recently? ☐ YES ☐ NO

    Do you know your results? Ie: cholesterol, ferritin levels, blood type? ☐ YES ☐ NO

    Explain:____

    ____

26. Have your hormones ever been checked to evaluate your hair loss? ☐ YES ☐ NO

    When, and what were the results?____

    ____

27. Have you ever been diagnosed with a Thyroid condition? ☐ YES ☐ NO
28. Have you ever been treated with a Thyroid hormone? ☐ YES ☐ NO
29. Are iron levels low to your knowledge? ☐ YES ☐ NO
30. Do you or a family member have any Autoimmune diseases?

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Name: ________________________ Date:________________________

Lupus ____Self ____Family Member
Rheumatoid arthritis ____Self ____Family Member
Graves Disease ____Self ____Family Member
Type 1 Diabetes ____Self ____Family Member
Other______________ ____Self ____Family Member

31. Do you have any scalp symptoms?(ex: itching, burning, pain, sensitivity)
_____itching ____tenderness ____pain ____burning ___Other

Explain location:____
____

32. Please list all treatments prescriptive and non-prescriptive that have been tried to restore your hair loss.

Treatment	When was it tried?	For how long?	Did it help?

33. What do you think caused your hair loss?____
____
____

34. Is there any other information that you would like to share?________________________________
____
____
____

35. What would your hair goal be?____
____
____
____

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