Hair Loss Intake Form
Name: _____ DOB: ____/____/_____

History of Hair Loss and Scalp Health

When did your hair loss begin (approximately)? _____

Where are you experiencing hair loss? □ Scalp □ Other areas _____
Is your hair loss: □ General □ Patches □ or Both
Was onset of hair loss: □ Sudden □ or Gradual
Since onset, has it gotten: □ Better □ Worse □ or Stayed the same
Is your hair: □ Thinning □ Shedding or Both
Does your scalp itch? □ No □ Mild □ Moderate □ Severe
Is your scalp flaking? □ YES □ NO

Hair Care and Styling

How often do you wash your hair? _____

What hair products do you use? _____
Do you use:

□ Hot rollers □ Relaxer/Keratin? □ Use hair dye
□ Rollers □ Curling iron □ Straightening iron
□ Other hair treatment chemicals: _____

How often do you use any of the above? _____
Do you regularly have any of the following hair styles:

□ Ponytails □ W eaves □ Braids
□ Extensions □ Twists □ Headbands
□ Dreadlocks

How often do you use any of the above? _____

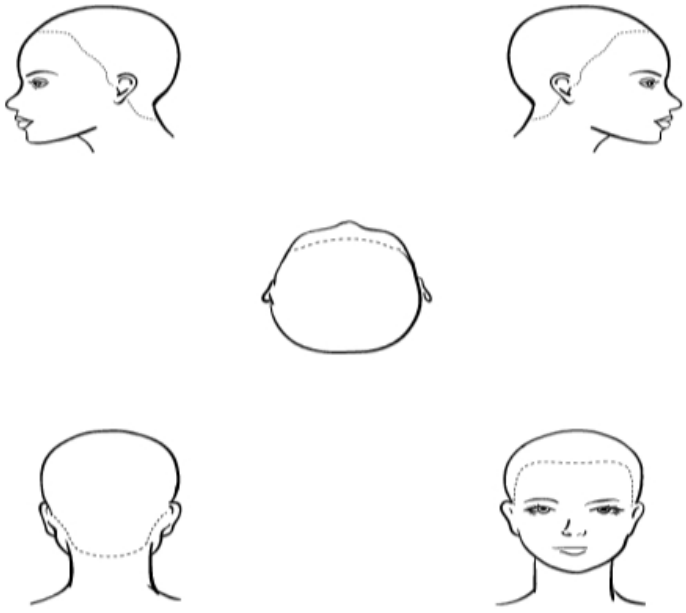
Where do you see hair? □ Home □ Shower □ Other: _____
How many hairs do you estimate you are losing at a time?

□ About a 100 □ More than 100 □ I don't know, but the hair is in clumps

Where have you noticed hair loss (CIRCLE ALL THAT APPLY)?

□ Top/front of scalp □ Sides of scalp □ Back of scalp □ Armpits
□ Groin □ Eyebrows □ Legs □ Eyelashes

Draw on the diagram where the hair loss is the most



Health History:

Do you have:

- ☐ Psoriasis
- ☐ Seborrheic dermatitis
- ☐ Double vision
- ☐ Cystic Acne
- ☐ Enlargement of clitoris
- ☐ Excess facial hair
- ☐ Excess body hair
- ☐ Discharge from breast
- ☐ Deepening of voice
- ☐ Polycystic ovary disease
- ☐ Do you have any divots/impressions/dots or ridges on your nails?
- ☐ History of Radiation
- ☐ History of chemotherapy
- ☐ History of thyroid disease
- ☐ History of crash dieting or rapid weight loss,
- ☐ History of Low levels of iron, zinc, and vitamin D
- ☐ low molecular weight heparin (and less commonly warfarin)
- ☐ History of autoimmune disease (please list):_____

In the last 3-12 months, have you experienced?

- ☐ High fever
- ☐ Childbirth
- ☐ Severe infection
- ☐ Flare of chronic illness
- ☐ Major surgery
- ☐ Start or stop beta blocker medication
- ☐ Start or stop hormone treatment
- ☐ Start or stop birth control pills
- ☐ Severe psychological stress
- ☐ prolonged illness or hospitalization

Any history of low libido, ejaculation, and orgasm problems
Any history of depression? ☐ YES ☐ NO ☐
Any history of sexual dysfunction? ☐ YES ☐ NO ☐
Have you recently dramatically changed your diet? ☐ YES ☐ NO ☐
Are you a vegetarian? ☐ YES ☐ NO ☐
Do you see a rash in your scalp or on your face? ☐ YES ☐ NO ☐
If yes, please describe: _____
Are you on any type of hormone treatment? ☐ YES ☐ NO
If YES, what type and for approximately how long? _____
Explain your history of hormone use: _____
_____

Female Patients Only

Do you have hair growth on your? ☐ Chin/thick sideburns ☐ Chest/nipples
☐ Area below your belly button

Are you using a hormonal birth control? YES ☐ NO ☐
If YES, what type and for approximately how long? _____
Or if you have recently stopped taking it, when did you stop? _____
If applicable, are your menstrual periods (check all that apply):
☐ Regular ☐ Irregular ☐ Light ☐ Moderate ☐ Heavy
Have you gone through menopause? YES ☐ NO ☐ If YES, what age? _____

Family History

Which family members have had hair problems (CIRCLE ALL THAT APPLY)
☐ Mom / Dad ☐ Siblings ☐ Children ☐ Grandparents

PREVIOUS TREATMENTS

List all other doctors, their specialty, and when treated for this problem? _____
_____
What lab tests were performed? _____
Was a biopsy performed? ☐ YES ☐ NO
Use of Minoxidil (Rogaine)? ☐ Past ☐ Present How long? _____
Strength (2 or 5%) Did it work? ☐ YES ☐ NO
Did it cause more hair to fall out in the beginning? YES OR NO
Any side effects?
Biotin YES OR NO dose:

Spironolactone/Aldactone Dose: _____ How long? _____

Shampoo/conditioner system like Viviscal YES OR NO

Finasteride(Propecia) Dose? _____ How long? _____-

Dutasteride Dose? _____ How long? _____-

LED light devices / helmets? Name _____ How long? _____

Ketoconazole shampoo How long? _____-

Steroid injections / Prednisone Use? Dose? _____ How long? _____-

Antibiotics (doxycycline, clindamycin, benzoyl peroxide) YES OR NO list:

Iron supplements (dose) YES OR NO dose:

Other vitamins (list:) _____

Any side effects from treatments(i.e scalp irritation, dizziness, hair growth in unwanted areas, breast enlargement, etc)

Has any treatment helped more than others (explain)?

SOCIAL IMPACT

What is your occupation? _____

How severely has it affected your life? _____

Are you fearful of becoming bald? _____

MEDICATIONS ASSOCIATED WITH HAIR LOSS Circle any medications taken since you noticed hair loss

Telogen Effluvium

Psychotropic Agents Lithium Sodium Valproate SSRIs (Fluoxetine)

Anticoagulants LMW heparins (enoxaparin, dalteparin) Warfarin

Cardiovascular Agents Beta Blockers (Metoprolol, Propranolol) ACE Inhibitors (Captopril)

Cessation of Oral Contraceptives

Retinoids Acetretin Isotretinoin Vitamin A supplements

Antimicrobials Isoniazid Antiretrovirals (Indinavir)

Anagen Effluvium

Chemotherapeutic Agents

Radiation

Androgenetic Alopecia (AGA)

Androgenic Agents: *May accentuate AGA*

Testosterone Anabolic Steroids DHEA Levonorgestrel (Mirena,certain contraceptives)

Please bring any lab testing and biopsy results from the other doctors and their last office visit note to your visit.

What goals or expectations do you have for treatment? _____

_____

Patient Signature: _____ Date: ____/____/_____