Hair Loss/Hair thinning/Alopecia

Patient History Form

We take hair loss very seriously due to the large impact it has on a patients' quality of life. We therefore devote an alopecia clinic appointment for patients with this problem where more time, attention and detail can be given for this condition. As part of this, you need to be prepared for your visit. Your visit will only be focused on this condition. Hair loss appointments will not include skin checks, acne evaluation, cosmetics, etc.

Guidelines for a productive visit include:

-Do not shampoo hair for 1-2 days before visit

-Bring a picture of your hair when it was not thinning

-Do not comb or brush your hair that morning

-Do not wear nail polish

-Do NOT bring a bag of hair. We will examine and may pluck hair during your visit

-Have all recent lab work available – either you have a copy for the visit or you signed a release form for us to receive from your doctor. If not done, anticipate lab testing.

-Have prior biopsy(ies) reports available – either you have a copy for the visit or you signed a release form for us to receive from your doctor. If not done, anticipate a possible biopsy.

ONSET

1. How long ago did the hair loss start? ______________________________
2. Did it happen rapidly "overnight"? YES OR NO
3. Who noticed the hair shedding/hair loss? ______________________________
4. Was your hair gray all of a sudden in a particular area? YES OR NO
5. Which family members have had hair problems (CIRCLE ALL THAT APPLY)
   a. Mom/Dad
   b. Siblings
   c. Children
   d. Grandparents
6. Is this the first and only time you have experienced hair loss? YES OR NO
   a. Is it different from the other time you experienced hair loss? Please explain.

      ____

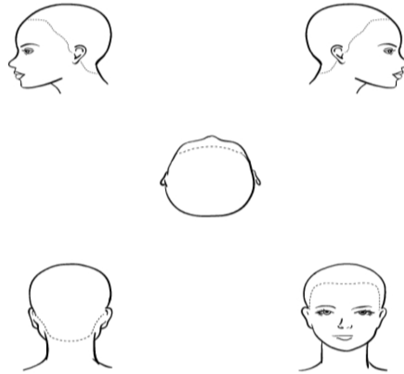
      ____

      ____

SYMPTOMS

7. Is the hair shedding (you can see the hair bulb) or is it breaking? ____________________
8. Does your hair have a dry texture? YES OR NO
9. Is your scalp?
    a. Flaking YES OR NO
    b. Itching YES OR NO
    c. Painful or tender YES OR NO
    d. Sensitive or irritated YES OR NO
    e. Greasy YES OR NO
    f. Red (assessed in the mirror or what other people say) YES OR NO
10. Does your scalp have a funny odor sometimes? YES OR NO
11. Do you dye your hair? YES OR NO
12. Do you have any divots/impressions/dots or ridges on your nails? YES OR NO
13. Where do you see hair?
    a. Home
    b. Shower
    c. Other: ____
14. How many hairs do you estimate you are losing at a time?
    a. 100 YES OR NO
    b. >100 YES OR NO
    c. I don't know, but the hair is in clumps YES OR NO
15. Where have you noticed hair loss (CIRCLE ALL THAT APPLY)?
    a. Top/front of scalp
    b. Sides of scalp
    c. Back of scalp
    d. Armpits
    e. Groin
    f. Eyebrows
    g. Legs
    h. Eyelashes

16. Draw on the diagram where the hair loss is the most?



17. Women, do you have hair growth on your?
    a. Chin/thick sideburns YES OR NO
    b. Chest/nipples YES OR NO
    c. Area below your belly button YES OR NO

TREATMENTS

18. What resources have you used to learn about hair loss?
    a. Internet YES OR NO
    b. Friends YES OR NO
    c. Any questions or concerns you have based on your research ____________

    ____

    ____
19. Have you seen another doctor for this problem? YES OR NO
    a. If yes, was lab testing performed? YES OR NO
       This must be brought to your visit or sent before your visit
    b. If yes, was a biopsy performed? YES OR NO
       This must be brought to your visit or sent before your visit
20. Are you using Rogaine/Minoxidil? YES OR NO
    a. Strength (2 or 5%) ______________________________
    b. How often (once or twice a day) ______________________
    c. Are you consistent with use? YES OR NO
    d. How long have you used it? __________________________
    e. Did it work? YES OR NO
    f. Did it cause more hair to fall out in the beginning? YES OR NO
    g. Any side effects? ______________________________

    ____
21. Are you using anything else to treat your hair loss?
    a. Biotin YES OR NO dose:________________

b. Spironolactone/aldactone (dose) YES OR NO dose:________________
c. Shampoo/conditioner system like viviscal YES OR NO
d. Finasteride/Propecia YES OR NO dose:________________
e. Dutasteride YES OR NO
f. LED light helmets YES OR NO
g. Ketoconazole shampoo YES OR NO
h. Prednisone YES OR NO dose:________________
i. Antibiotics (doxycycline, clindamycin, benzoyl peroxide) YES OR NO
   list:____
j. Prior steroid injections YES OR NO
k. Iron supplements (dose) YES OR NO dose:________________
l. Other vitamins (list:) ____
   ____

22. Any side effects from treatments(i.e scalp irritation, dizziness, hair growth in unwanted areas, breast enlargement, etc) ________________________________
    ____
    ____
23. Has any treatment helped more than others (explain)?________________________
    ____
24. What goals or expectations do you have for treatment? ______________________
    ____
    ____

SOCIAL IMPACT

25. What is your occupation? ________________________________
26. How severely has it affected your life? ________________________
    ____
    ____
    ____
27. Are you fearful of becoming bald? ________________________________
    ____

DERMATOLOGY LIFE QUALITY INDEX (adapted) – this screening will be repeated at future visits

Name: Date: Score:

The aim of this questionnaire is to measure how much your hair loss has affected your life OVER THE LAST WEEK. Please tick ☑ one box for each question.

1.	Over the last week, how **itchy**, **sore**, **painful** or **stinging** has your scalp been?	Very much	❒	
		A lot	❒	
		A little	❒	
		Not at all	❒	
2.	Over the last week, how **embarrassed** or **self conscious** have you been because of your hair loss?	Very much	❒	
		A lot	❒	
		A little	❒	
		Not at all	❒	
3.	Over the last week, how much has your hair loss interfered with you going **shopping** or looking after your **home?**	Very much	❒	
		A lot	❒	
		A little	❒	
		Not at all ❒	Not relevant ❒	
4.	Over the last week, how much has your hair loss influenced the **clothes** you wear like hats?	Very much	❒	
		A lot	❒	
		A little	❒	
		Not at all ❒	Not relevant ❒	
5.	Over the last week, how much has your hair loss affected any **social** or **leisure** activities?	Very much	❒	
		A lot	❒	
		A little	❒	
		Not at all ❒	Not relevant ❒	
6.	Over the last week, how much has your hair loss made it difficult for you to do any **sport**?	Very much	❒	
		A lot	❒	
		A little	❒	
		Not at all ❒	Not relevant ❒	
7.	Over the last week, has your hair loss prevented you from **working** or **studying**?	Yes	❒	
		No	❒	Not relevant ❒

	If "No", over the last week how much has your hair loss been a problem at **work** or **studying**?	A lot	❒
		A little	❒
		Not at all	❒
8.	Over the last week, how much has your hair loss created problems with your **partner** or any of your **close friends** or **relatives**?	Very much	❒
		A lot	❒
		A little	❒
		Not at all ❒	Not relevant ❒
9.	Over the last week, how much has your hair loss caused any **sexual difficulties**?	Very much	❒
		A lot	❒
		A little	❒
		Not at all ❒	Not relevant ❒
10.	Over the last week, how much of a problem has the **treatment** for your hair loss been, for example by making your home messy, or by taking up time?	Very much	❒
		A lot	❒
		A little	❒
		Not at all ❒	Not relevant ❒

Please check you have answered EVERY question. Thank you.

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Check the box(es) if you are experiencing any of the following:

- ☐ Problem with bleeding
- ☐ Excessive fatigue
- ☐ Dry eyes
- ☐ Unintentional weight loss or gain
- ☐ Staphylococcal infections
- ☐ Problems with scarring (hypertrophic or keloid)
- ☐ Artificial heart valve
- ☐ Artificial joints placed within the past two years
- ☐ Blood thinners (aspirin, warfarin)
- ☐ Defibrillator
- ☐ Allergy to lidocaine/anesthetics
- ☐ Allergy to topical antibiotic (Neosporin)
- ☐ Problems with healing
- ☐ Joint or back aches
- ☐ Change in vision or blurry vision
- ☐ Abdominal pain
- ☐ Migraines
- ☐ Irregular menses/periods
- ☐ Dry mouth
- ☐ Hair loss
- ☐ Rash with use of adhesive bandages
- ☐ Currently pregnant or planning a pregnancy
- ☐ Leg swelling
- ☐ Muscle Weakness

Past Medical History (Please circle all that apply)

Anxiety	Asthma	Hay Fever/Allergies	Depression	Diabetes
Kidney Disease	Liver disease	HIV/AIDS	Thyroid Problems	Leukemia
Lymphoma	Radiation Treatment		Sjogren's syndrome	Lupus

Past Surgical History: (please circle all that apply)
Mechanical Heart Valve Replacement
Biological Heart Valve Replacement
Joint Replacement within last 2 years
Bone Marrow Transplantation
Organ Transplantation

Skin Disease History: (please circle all that apply)

Acne Blistering Sunburns Dry Skin Eczema Flaking or Itchy Scalp
Sun sensitivity Psoriasis

Family History:

Eczema: siblings /mother / father / child / grandparents
Psoriasis: siblings /mother / father / child / grandparents

Medications: Please all medications you take from other doctors and **length of therapy**

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