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Hair Problem Questionnaire

Patient Name/DOB: _____ Date: _____

Hair History

Which of the following problems are you currently experiencing:

❒ Hair Loss ❒ Excessive Hair Growth

Which area(s) of your body do you notice the hair loss or growth:

❒ Upper Lip ❒ Scalp ❒ Eye Brows ❒ Eye Lashes ❒ Under Arm ❒ Pubic Area

When did the problem begin or when did you notice it: _____

How would you describe the progression of your hair problem:

❒ Slow Onset ❒ Slow Progression ❒ Abrupt Onset ❒ Rapid Progression

Did the problem first occur after any of the following:

❒ Using a New Hair Product ❒ Traumatic Event ❒ Recent Pregnancy

Do you have any psychiatric problems or stress: ❒ Yes ❒ No

Do you do any of the following to your hair:

❒ Perms ❒ Vigorously Brush ❒ Compulsively Pull

Have you experienced any of the following: ❒ Yes ❒ No then check the box that applies if yes

❒ Irregular Menstrual Cycle ❒ Infertility ❒ Enlargement of the Clitoris
❒ Deeping of the Voice ❒ Increased Libido ❒ Loss of Female Body Contour
❒ Skin Pigmentation ❒ Hot Flashes ❒ Discharge from Breast(s)

Do you have a history of any of the following: ❒ Yes ❒ No then check the box that applies if yes

❒ Thyroid Disease ❒ Adrenal Disease ❒ Polycystic Ovarian Syndrome
❒ Ovarian Disease ❒ Diabetes Mellitus ❒ Insulin Resistance Syndrome
❒ Cushing's Syndrome ❒ Lupus ❒ Lymphoma
❒ Calcium Disorder ❒ Dermatomyositis

Do you take or use any of the following: ❒ Yes ❒ No then check the box that applies if yes

❒ Hydrocortisone ❒ Anabolic Steroids ❒ Testosterone ❒ Danazole
❒ Rogaine ❒ Thyroid Medication ❒ Minoxidil

Does your spouse or partner use testosterone gel that gets applied onto the skin? ❒ Yes ❒ No

Have you had radiation therapy? ❒ Yes ❒ No

Have you had chemotherapy? ❒ Yes ❒ No