CHARLOTTE SKIN & LASER
Elizabeth Rostan MD

Patient Name: _____

D.O.B: _____

Date: _____

Hair Loss Questionnaire

1. Where have you noticed hair loss on scalp?
   Circle: All over/front/back/sides

2. How long have you experienced hair loss?

3. How do you notice hair loss?
   Circle: constant shedding/occasional shedding/bald spots/
   Increased hair in shower or brush

4. Do you have history of:
   Circle: anemia/low iron/heavy periods/thyroid problems

5. Any recent surgery?

6. Any recent illness?

7. Any recent weight loss?

8. Do you have a special diet?
   If yes, circle: vegetarian/vegan/low fat/ low calorie

9. Have you recently been pregnant or breastfeeding?

10. Any history of stress, anxiety or depression?

11. Any family history of hair loss? If yes, who?
    Circle: grandmother/mother/sister/aunt/grandfather/father/
    brother/uncle

12. Any recent blood tests? Yes/No If yes, any abnormal?

13. Have you ever had a scalp biopsy?

14. Have you had any previous treatments for hair loss?
    If yes, which ones?

15. Any history of flaking or itching of scalp?

16. Any history of chemical treatments, perms or tight braids to hair?
    If yes, how recently and how often?